Operational Standards
For
Mental Health,
Intellectual/Developmental Disabilities,
And Substance Use Disorders
Community Service Providers

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Title 24: Mental Health

Part 2: Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers

Part 2: Chapter 1: Certification Responsibilities of the Mississippi Department of Mental Health

Rule 1.1 Repeal of Prior Rules

Upon their effective date, these rules and regulations supersede and repeal all previous versions of the Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Use Disorders Community Service Providers.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 1.2 Legal Authority

A. The State of Mississippi vested standard-setting authority in the DMH through Section 41-4-7 of the *Mississippi Code, 1972, as amended*, which authorizes the Department to:

1. supervise, coordinate, and establish standards for all operations and activities of the state, related to mental health and providing mental health services;

2. certify, coordinate and establish minimum standards and establish minimum required services for regional mental health and intellectual disability commissions and other community service providers for community or regional programs and services in mental health, intellectual disability, alcoholism, drug misuse, developmental disabilities, compulsive gambling, addictive disorders and related programs throughout the state; and,

3. establish and promulgate reasonable minimum standards for the construction and operation of state and all DMH certified facilities, including reasonable minimum standards for the admission, diagnosis, care, treatment, transfer of patients and their records, and also including reasonable minimum standards for providing day care, outpatient care, emergency care, inpatient care and follow-up care, when such care is provided for persons with mental or emotional illness, intellectual disability, alcoholism, drug misuse and developmental disabilities.

B. Mental Health Services described in these regulations are approved therapeutic and case management services provided by (a) an approved regional mental health/intellectual disability center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health (DMH) to be an approved mental health/intellectual/developmental center if determined necessary by DMH, using state funds which are provided from the appropriation to DMH and/or funds transferred to the department by a political subdivision or instrumentality of the state and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior authorization of the Division of Medicaid to be eligible for reimbursement under this section.

C. As described in Senate Bill 2829 of Regular Session 2014, regional commissions can create and operate a primary care health clinic to treat (a) its patient; (b) its patients' family members related within the third degree; and (c) its patients' household members or caregivers. Regional commissions operating a primary care health clinic must satisfy applicable state and federal laws and regulations regarding the administration and operation of a primary health care clinic. DMH does not have the statutory authority to license, certify or monitor primary care health clinics.

Source: Section 43-13-117(16) of *the Mississippi Code, 1972, as amended*
Section 41-19-33 *of the Mississippi Code, 1972, as amended*

Part 2: Chapter 2: Certification

Rule 2.1 DMH Provider Certification Types

A. Certification by the Mississippi DMH of any type is not a guarantee of funding from any source. Funding is a separate process and each individual funding source/agency must be contacted for information regarding their requirements for funding and the process required for obtaining that funding.

B. Certification by the Mississippi DMH of any type is not a guarantee of designation as a DMH Mental Health/Intellectual Disability/ Substance Use Disorder Community Service Provider.

C. DMH/Department (DMH/D): Programs that are operated under the authority and supervision of the State Board of Mental Health authorized by Section 41-4-7 of the *Mississippi Code of 1972, Annotated*, must be certified. These are the community based services, including those community mental health service providers meeting DMH requirements of and determined necessary by DMH to be an approved Community Mental Health Center, operated by the state regional centers and the state psychiatric/chemical dependency hospitals.

D. DMH/CMHC (DMH/C): Providers that are certified under this option are Community Mental Health Centers operating under the authority of regional commissions established under 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*, and other community mental health service providers operated by entities other than the DMH that meet requirements of and are determined necessary by DMH to be a designated and approved mental health center.

E. DMH/Private Provider (DMH/P): Providers certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior authorization of the Division of Medicaid to be eligible for reimbursement under this section. DMH is not responsible for any required matching funds for reimbursement for this provider certification type.

F. DMH/Grants (DMH/G): Providers other than those designated as DMH/D and DMH/C above that receive funds for services through grants from the Mississippi DMH must be certified. These include nonprofit providers that receive funds directly from the DMH, but that are not Community Mental Health Centers (DMH-C designation) or DMH-operated (DMH/D designation).

G. DMH/Home and Community-Based Waiver (DMH/H): Providers meeting requirements for certification to provide services under the Home and Community-Based Services-ID/DD Waiver must be certified by DMH. All DMH/H Providers must be enrolled as a Medicaid provider for ID/DD Waiver Services prior to service delivery. Entities that

may apply include those already certified by the DMH as well as other entities that provide the type services offered through the ID/DD Waiver.

H. DMH/Other Agency Requirement or Option (DMH/O): Private nonprofit and private for-profit providers that receive funds from agencies other than the Mississippi DMH (such as from the Mississippi Department of Rehabilitation Services and the Mississippi Department of Human Services) may be required by that agency to obtain DMH certification. These providers will be designated as DMH/O programs if applicable DMH Standards are met.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*
Section 43-13-117 of the *Mississippi Code, 1972, as amended*

Rule 2.2 Fees

A. A fee may be charged by the DMH for certification or recertification depending on the certification option the provider chooses and the legal status of the applicant organization (i.e., private non-profit, private for-profit, public, etc.). After submitting an initial application, the applicant will be contacted in writing by the DMH notifying the provider of the fee (if applicable). The fee must be submitted to the DMH prior to the initial on-site visit.

B. A fee to conduct the initial certification visit of $350.00 per DMH staff person per day may be charged to programs seeking DMH/O, DMH/P and providers seeking DMH/H certification. Those programs seeking or holding a DMH/D, DMH/C, a DMH/G certificate, will be exempt from fees.

C. Recertification or other review visits may require a fee of $150.00 per DMH staff person per day, which will be billed to the provider after the on-site visit.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.3 DMH Provider Certification for New Service Providers

A. A new service provider is defined as an organization that is seeking DMH certification as a service provider with organizational and management structures in place to meet requirements outlined in DMH Operational Standards to begin service provision.

B. New Service Providers interested in DMH Certification must complete DMH Provider Orientation prior to seeking certification. DMH Provider Orientation must be completed prior to submitting the application for DMH Provider Certification.

C. New Service Providers interested in DMH Certification must submit the required DMH application and supporting documentation and adhere to the timelines and procedures for application.

D. DMH certification for all new service provider organizations is a two-step process.

1. First, a service provider organization must receive DMH Provider Certification.
2. Second, the DMH certified provider must apply for DMH certification of the services they seek to provide and the applicable program locations in which the services are provided. *(Note: not all services will require a physical program location)*

E. DMH will notify the Division of Medicaid of a provider's certification status.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.4 DMH Provider Certification of New or Additional Services

A. All DMH Certified Providers seeking DMH certification of new or additional services must submit the completed DMH Service Certification Application and supporting documentation to the Division of Certification for review. Applicants must adhere to the timelines and procedures for application. Incomplete applications will not be considered for review.

B. All services and program locations must be certified by DMH, with written documentation of effective certification period prior to service delivery and seeking reimbursement for services. DMH will notify the Division of Medicaid of a provider's certification status.

C. In addition to the requirement of Rule 2.4.A-B providers seeking DMH certification to provide Host Home Services must provide documented evidence of at least two (2) years of experience of managing and provide Host Home Services to include organizing, certifying and managing Host Home families.

D. In addition to the requirement of Rule 2.4 A, entities applying for certification as a Opioid Treatment Program must include the following:

1. Program goals and objectives;
2. Program funding (including individual fee schedules);
3. Demonstrated need to establish the program.
   (a) Submit sufficient justification to include:
      (1) Location population data
      (2) Agencies plan for service implementation
      (3) Identified Gaps in service
      (4) Expected target population

(5) Sufficient documentation of support for services in the form of a signed letter from at least one of the following:
   i. Individuals
   ii. Businesses
   iii. Property-owners residing/located within the immediate area surrounding the proposed location
(6) Sufficient documentation of need in the form of a signed letter from at least one of the following:
   i. Behavioral health program
   ii. Area physician
   iii. Other health professional/agency
(7) Sufficient documentation of support for services in the form of a signed letter from at least one of the following:
   i. Local governing authorities
   ii. Local law enforcement officials
   iii. Local judges

E. Opioid Treatment Program will not be approved if its location is in an area where needs are met by existing services. The DMH determination of need will include but is not limited to population census, existing services, and other pertinent data. This applies to initial and future satellite or branch sites of Opioid Treatment Program(s).

F. Opioid Treatment Program utilizing methadone must be located in an area that is properly zoned in accordance with local ordinances and requirements.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.5 DMH Certification Criteria

A. DMH issues Provider, Service, and Program Certifications for a three (3) year certification cycle unless stated otherwise at the time of certification.

B. DMH Certification is based on the following:

1. Provision of applicable required services in all required locations for desired certification option;
2. Adherence to DMH standards, DMH grant requirements (if applicable) guidelines, contracts, memoranda of understanding, and memoranda of agreement;
3. Compliance with DMH fiscal management standards and practices;
4. Evidence of fiscal compliance/good standing with external (other than DMH) funding sources;
5. Compliance with ethical practices/codes of conduct of professional licensing entities related to provision of services and management of the organization; and
6. Evidence of solid business and management practices.

C. In addition to complying with the appropriate areas of the current DMH Operational Standards for MH/IDD/ SUD Community Providers, a program or provider must comply with special guidelines and/or regulations issued by the DMH for the operation of programs and services and must update the Policies and Procedures Manual(s) and other documentation as required by these guidelines and/or regulations.

D. In addition to applicable standards, programs certified and/or funded by the Mississippi DMH must comply with any additional specifications set forth in individual program grants/contract as well as with the requirements outlined in the DMH Record Guide.

E. Providers must maintain current and accurate data for submission of all reports and data, within established time frames, as required by the DMH according to the DMH Manual of Uniform Data Standards.

F. Providers must comply with requirements of DMH Provider Bulletins.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.6 Certification Reviews

A. Administrative and On-Site Compliance Reviews will take place (if applicable) for the certification of the following:

1. New service provider organizations
2. New services or program locations for an existing DMH Certified Provider
3. Additional services or program locations for an existing DMH Certified Provider
4. Adherence to an accepted Plan of Compliance
5. During the certification period of a certified provider to ensure continued adherence to DMH Operational Standards, guidelines, contracts, and grant requirements. DMH reviews may be unannounced.

B. Administrative Compliance Reviews are defined as reviews during which DMH requests information (such as policies and procedures, staffing plans, staff training, minutes of governing authority, etc.) be submitted from the provider for a DMH administrative review.

C. On-site Compliance Reviews are defined as reviews that are conducted by DMH at the administrative, service or program location.

D. All DMH funded/certified providers, services and programs are subject to a DMH-approved peer review/quality assurance evaluation process.

1. The Peer Review Program is committed to the involvement of consumers, family members, mental health professionals and interested stakeholders in program

evaluation and moving the system toward a person driven, recovery/resiliency oriented system.

2. The goal of the Peer Review Program is to advocate for excellence in services through the voices of the people being served, to improve care in the public mental health system, and to ensure services meet the expressed needs of individuals receiving services.
3. Consumers, Family members, mental health professionals and interested stakeholders comprise the peer review team. Team members obtain information from peers and program staff about satisfaction with services, quality of life measures, support provided from professional staff; review programs and case records (when applicable); and dialogue with mental health administrators. The team provides feedback to providers and DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.7 DMH Written Reports of Findings

If found to be out of compliance with the criteria for DMH Certification during an administrative or on-site compliance review, DMH will issue a Written Report of Findings to the Executive Director and Chairperson of the Governing Authority of the provider organization within thirty (30) days of the last day of the compliance review. The provider is informed that termination of certification will be effective within one hundred and twenty (120) calendar days from the last day of the review. The termination date will be included in the Written Report of Findings.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.8 Plan of Compliance

A. Upon receipt of a DMH Written Report of Findings, a DMH Certified Provider must submit a Plan of Compliance (POC) in the required format included in the DMH Record Guide to the Division of Certification within thirty (30) days of the date of the Written Report of Findings. The POC must address the corrective action by the Provider, date of corrective action, timelines for completion of corrective action, and measures put in place to maintain compliance and prevent future occurrence. Should the provider not submit a POC within the required timeframe, the process to terminate certification will continue as stated in Rule 2.7. DMH will not make additional requests for a POC to be submitted.

B. Timelines for the submission of a POC may be revised due to the nature of findings. If applicable, DMH will notify the Certified Provider of a revision in timelines in the Written Report of Findings.

C. If the POC is accepted by DMH, the Provider will be notified in writing within thirty (30) days of the date of DMH receipt of the POC.

D. If the POC is not found to be acceptable by DMH, the Provider will be notified in writing within thirty (30) days of the date of DMH receipt of the POC. If the POC is not accepted by DMH, the Provider is notified in writing that the termination of certification will be effective as stated in the DMH Written Report of Findings.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.9 Administrative Suspensions or Termination of Certification

A. Based on issues of noncompliance, DMH may determine the need to take administrative action to suspend, revoke or terminate certification. This decision is made by the DMH Executive Director or his designee.

B. A determination that the certification status may be suspended or terminated shall be made upon any of the following criteria:

1. Failure to comply with DMH Operational Standards;
2. Failure to comply with guidelines, contracts, memoranda of understanding, and memoranda of agreement;
3. Failure to comply with DMH fiscal requirements;
4. Failure to provide services for a period of twelve months;
5. Defrauding an individual receiving services, individual that may potentially receive services, and/or third party payer sources;
6. Endangerment of the safety, health, and/or the physical or mental well-being of an individual served by the provider agency;
7. Inappropriate or unethical conduct by provider staff or its governing authority; or
8. Any other just cause as identified by the MS State Board of Mental Health/DMH Executive Director.

C. DMH will notify the Executive Director and the Chairperson of the governing authority of the provider agency in writing of an administrative suspension or termination and the criteria for which that determination was made.

D. Should DMH Administratively suspend a certified provider, service or program, the Executive Director of the provider agency will have the opportunity to submit a POC to DMH for approval in order to have the administrative suspension lifted. The timelines for submission of the POC in Rule 2.8 will apply unless otherwise stated by DMH.

E. Should DMH terminate the certification of a provider, the provider cannot reapply for DMH certification for a period of one year from the date of the termination.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 3: Service Options

Rule 3.1 Core Services for DMH/C and DMH/P Providers

A. Community Mental Health Centers operated under the authority of regional commissions established under MCA Section 41-19-31 et seq. and other community mental health service providers operated by entities other than the DMH that meet DMH requirements of and are determined necessary by DMH to be a designated and approved mental health center must provide the following core services in each county in the CMHC's entire catchment area and in each county identified by DMH/P providers:

1. Adult Mental Health Services

    a. Outpatient Therapy
    b. Community Support Services
    c. Psychiatric/Physician Services
    d. Crisis Response Services
    e. Psychosocial Rehabilitation
    f. Inpatient Referral
    g. Pre-Evaluation Screening for Civil Commitment (required only for centers operated by regional commissions est. under MCA Section 41-19-31 et seq.)
    h. Peer Support Services
    i. Targeted Case Management Services
    j. Support for Recovery/Resiliency Oriented Services

2. Children and Youth Mental Health Services

    a. Day Treatment Services
    b. Outpatient Therapy
    c. Community Support Services
    d. Psychiatric/Physician Services
    e. Crisis Response Services
    f. Pre-Evaluation Screening for Civil Commitment (for youth age 14 and over)
    g. Making a Plan (MAP) Teams
    h. Targeted Case Management Services
    i. Peer Support Services
    j. Support for Recovery/Resiliency Oriented Services

3. Substance Use Disorders Services

    a. Outpatient Services
    b. Crisis Response Services
    c. Prevention Services
    d. Peer Support Services
    e. Support for Recovery/ Resiliency Oriented Services

4. Intellectual/Developmental Disabilities Services

    a. Crisis Response Services

B. Community Mental Health Centers operated under the authority of regional commissions established under MCA Section 41-19-31 et seq. and other community mental health service providers operated by entities other than the DMH that meet DMH requirements of and are determined necessary by DMH to be a designated and approved mental health center (DMH/C) must provide the following core services for individuals in need of substance use disorders treatment and rehabilitation services residing in the CMHC's entire catchment area:

    1. Primary Residential Services (adults)
    2. DUI Assessment Services
    3. Recovery Support Services

Source: Section 41-4-1 of the *Mississippi Code, 1972, as amended*

<u>Rule 3.2 Intellectual/Developmental Disabilities Waiver Services</u>

A. Services available through the ID/DD Waiver include:

    1. Support Coordination
    2. Home and Community Supports
    3. In-Home Nursing Respite
    4. In-Home Respite
    5. Day Services – Adult
    6. Prevocational Services
    7. Supported Employment
    8. Supported Living
    9. Shared Supported Living
    10. Supervised Living
    11. Host Homes
    12. Community Respite
    13. Crisis Intervention
    14. Crisis Support
    15. Behavior Support
    16. Job Discovery
    17. Transition Assistance

Source: Section 41-4-1 of the *Mississippi Code, 1972, as amended*

Rule 3.3 IDD Community Support Program Services

A. Services available through the IDD Community Support Program include:

1. Day Habilitation
2. Prevocational Services
3. Supported Employment

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 4: Certificates of Operation

Rule 4.1 Certificates of Operation

A. All certified providers, services and programs must have a DMH Certificate of Operation.

B. The following apply to a Certificate of Operation:
   1. The valid dates of certification, service(s), or programs certified, including the physical location, site capacity of the program, if appropriate, and the certificate number will be specified on the Certificate of Operation issued by the DMH;
   2. A Certificate of Operation is not transferable;
   3. A Certificate of Operation is valid only for the service(s) or programs, physical location, and capacity identified on the certificate (in those cases where a definitive number or a quantitative capacity can be assigned to a service or program);
   4. Site capacities must not exceed the number identified on the Certificate of Operation;
   5. Certification for any established period, service or program is contingent upon the program's continual compliance with current Operational Standards for Mental Health, Intellectual/Developmental Disabilities and/or Substance Use Disorders Community Service Providers as established by the DMH;
   6. The Certificate of Operation must be posted in each of the certified sites for public view;
   7. Certificates for closed services and/or programs must be removed from the site and returned to the DMH within fifteen (15) days of the last day individuals were served.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 5: Waivers

Rule 5.1 Waivers of DMH Standards

A. A waiver of a specific standard may be requested and granted for a specified amount of time, determined on a case-by-case basis by the DMH, in accordance with the following procedures in this rule:

B. To request a waiver of a specific standard, the provider's Executive Director must make a written request to the Division of Certification. The request must:

1. List the standard(s) for which a waiver is being requested
2. Describe, in detail, all operational systems, personnel, etc., which function to meet the intent or objective of the standard
3. Provide justification that the waiver of the standard, if approved, will not diminish the quality of service
4. Designate individual program location(s) for which the waiver is requested
5. Specify the length of time for which the waiver is requested.

C. The DMH Review Committee and other personnel, as appropriate, will review the waiver request, and the Committee will approve or deny the request.

D. The Executive Director of the provider agency making the request will be notified of the decision within thirty (30) days of receipt of the request. Should DMH request additional information to make a determination regarding the waiver request, DMH has thirty (30) days from the date the requested information is received to make a determination and notify the Executive Director of the provider agency of the decision.

E. Should the requested information not be provided to DMH, Division of Certification within (30) days of the date DMH requests additional information needed to make a determination regarding a waiver request, the waiver request will be considered void. The provider agency requesting the waiver will be required to resubmit the request. Void waiver requests will not be kept on file.

F. Appeal of the denial of requests for waivers must be in accordance with Chapter 6 - Appeal Procedures.

G. Waivers granted by DMH serve only to waive a DMH Standard.

H. DMH waivers are time-limited for the time designated at the time the waiver is granted.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 6: Appeals

Rule 6.1 Appeals Related to Certification

A. Any provider applying for and/or holding certification by the DMH may appeal the following decisions and/or penalties:

   1. Disapproval of a Plan of Compliance;
   2. Any financial penalties invoked by DMH associated with noncompliance with the Operational Standards and/or audit findings;
   3. Denial of a request for a waiver of a DMH Operational Standard; or
   4. Termination of Certification.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 6.2 Procedures for Appeal

A. All appeals must be initiated by filing a written notice of appeal from the Executive Director or Governing Authority by certified mail in an envelope clearly marked Notice of Appeal or by email with Notice of Appeal in the subject line with the DMH Deputy Director and a copy to the Mississippi Department of Mental Health attorney within ten (10) days from the date of the final notification by the Department of Mental Health of the decision(s) being appealed (described above). The effective action of the decision(s) being appealed shall not be stayed during the appeal process except at the discretion of the Executive Director.

B. The written notice of appeal must have as its first line of text Notice of Appeal in bold face type (specifically stating that the notice is in fact an appeal).

C. The written notice of appeal must contain:
   1. A detailed statement of the facts upon which the appeal is based, including the reasons justifying why the program disagrees with the decision(s) and/or penalty(ies) imposed by the Department of Mental Health under appeal; and
   2. A statement of the relief requested.

D. The Deputy Director will conduct the first level of review.

E. If the Deputy Director determines that the appeal merits the relief requested without any additional information requested by Deputy Director and/or DMH attorney, the appellant will be notified that the relief requested is granted within ten (10) days of receipt of the written appeal.

F. If the Deputy Director determines that additional information is needed to make a decision or recommendation, additional written documentation from the appellant may be

requested within 10 days of receipt of the appeal. The Deputy Director will specify a time line by which the additional information must be received.

G. Within ten (10) days of the time set by the Deputy Director for his/her receipt of the additional information requested (described in F. above), the Deputy Director will:

1. Determine that the appeal merits the relief requested and notify the appellant that the relief requested is granted; or
2. Determine that the appeal does not merit the relief requested and issue a recommendation of such, justifying denial of the appeal to the Executive Director of the Department of Mental Health, who will conduct the second level of review of the appeal.

H. Within ten (10) days of receipt of a recommendation for denial of an appeal from the Deputy Director (as described in G.2. above), the Executive Director of the Department of Mental Health will make a final decision regarding the appeal and notify the appellant of the decision.

I. Time lines for review of appeals by the Deputy Director and Executive Director may be extended for good cause as determined by the Department of Mental Health.

J. If the Executive Director concurs with the findings of the Deputy Director to deny the appeal, the appellant may file a written request by certified mail in an envelope clearly marked Notice of Appeal and addressed to the Executive Director's office or by email with the Notice of Appeal in the subject line, requesting a review of the appeal by the Mississippi State Board of Mental Health. The request must be received by the Department within ten (10) days after the date of the notice of the Executive Director's decision to deny the appeal.

K. The written notice of appeal described in J. above must have as its first line of text Notice of Appeal in bold face type (specifically stating that the notice is in fact an appeal).

L. The written request for review of the appeal by the Mississippi State Board of Mental Health must contain:

1. A detailed statement of the facts upon which the request for review of appeal is based, including the reasons justifying why the program provider disagrees with the decision(s) by the Executive Director of the Department of Mental Health; and
2. A statement of the relief requested.

M. The Mississippi State Board of Mental Health review of appeals under this section will be in compliance with the established policy of the Board regarding appeals.

N. The Mississippi State Board of Mental Health review of appeals under this section may be based upon written documentation and/or oral presentation by the appellant, at the discretion of the Board.

O. Decisions of the Mississippi State Board of Mental Health are final.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 7: General Related to Certification

Rule 7.1 Access

A. Representatives of the DMH, displaying proper identification, have the right to enter upon or into the premises of any provider, program or facility it certifies at all reasonable times. The provider must comply with all reasonable requests to obtain information and to review individual cases, personnel and financial records and any other pertinent information. Failure to comply with legitimate requests may result in certification being withdrawn.

B. DMH program and fiscal staff have authority to interview personnel individually and individuals receiving services (if appropriate as determined by DMH) concerning matters regarding programmatic and fiscal compliance, including follow-up on matters reported to the DMH's Office of Consumer Support. Failure to comply with requests for such interviews will result in termination of the audit/review and possible discontinuance of funding and DMH certification.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 7.2 Technical Assistance

The DMH may provide, upon written request from the provider, technical assistance to applicants in maintaining requirements for certification. Additionally, the DMH may provide and/or facilitate other technical assistance when deemed necessary by the DMH. Technical assistance is not limited to, but may consist of contacts between DMH staff and the program staff via written correspondence, phone consultation, and/or personal visit(s).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 7.3 Changes to be Reported to DMH

A. Following certification, changes affecting the governing and/or operation of programs must be reported in writing to the Division of Certification. Anticipated changes must be reported before they take place. Changes not anticipated must be reported as soon as they occur. Failure to report any changes described in this section may result in loss of certification.

B. Examples of the significant changes that must be reported to the DMH before they occur include, but are not limited to:

    1. Changes in the governing authority, executive and key leadership
    2. Changes in ownership or sponsorship

3. Changes in staffing that would affect certification status
4. Changes in program site location
5. Increase in the capacity above that specified on the DMH certificate
6. Changes in program scope (such as major components of a service, age ranges and/or the population served, etc.)
7. Major alterations to buildings which house the program(s)
8. Changes in operating hours
9. Change(s) in the name(s) and/or locations of program(s) certified by the DMH.

C. Examples of significant changes that must be reported as soon as they occur include, but are not limited to:

1. Termination of operation (closure) for a period of one (1) day or more due to inclement weather or other unforeseen circumstances.
2. Termination or resignation of the governing authority member(s), Executive Officer, and key leadership.
3. Litigation that may affect service provision.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 8: Organization and Management

Rule 8.1 Governing Authority

A. The provider must have documented evidence of the source of its governing authority, whether corporate non-profit, corporate for-profit, sole proprietorship, charitable or governmental board/commission, or other such authority.

B. If the governing authority is a corporate non-profit or a charitable or governmental board/commission the governing authority must have and comply with bylaws and/or policies that:

1. Establish in writing the means by which the governing authority provides for the election or appointment of its officers and members and the appointment of committees necessary to carry out its responsibilities;
2. Show documentation of the adoption of a schedule of meetings and quorum requirements;
3. Require at least quarterly meetings;
4. Provide assurance that the governing authority does not consist of employees or immediate family members of employees;
5. Provide assurances that meetings of the governing authority are open to the public and include procedures for notifying the public of meetings;
6. Assure that governing authority members do not receive a per diem that exceeds the state limit;
7. Require the minutes of meeting, which are to include, but not be limited to:
   (a) The date of the meeting
   (b) Names of members and other participants/visitors attending
   (c) Topics and issues discussed, motions, seconds, and votes
   (d) Public comments; and
8. Establish an organizational structure as evidenced by an organizational chart.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 8.2 Annual Review by Governing Authority

A. The governing authority of all providers must have written documentation of the following:

1. Annual budget
2. Written affiliation agreements
3. All changes in policies and procedures
4. Annual Operational Plan submitted to DMH
5. Disaster and Continuity of Operations Plan
6. Process for meaningful individual and family involvement in service system planning, decision making, implementation and evaluation. Individuals should be

provided the opportunity for meaningful participation in planning at least for their service area.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 8.3 Regional MH/IDD Commissions

A. Regional Commissions established must describe in their bylaws and/or policies their duties as designated under Section 41-19-33 (a) through (w) of the *Mississippi Code 1972, Annotated.*

B. Regional Commissions must also maintain written documentation of the following:

1. Public education activities (presentations, distribution of printed materials, other media) designed to promote increased understanding of the problems of mental illness, behavioral/emotional disorders of children, intellectual/developmental disabilities, alcoholism, developmental and learning disabilities, narcotic addiction, drug abuse and drug dependence and other related problems including the problems of the aging and those used to promote increased understanding of the purposes and methods of rehabilitation of such illnesses or problems.
2. Documentation of hazard, casualty or worker's compensation insurance, as well as professional liability insurance.
3. Written approval of the DMH and/or the County Board of Supervisors, depending on the original source of funding, prior to the disposal of any real and personal property paid for with state and/or county appropriated funds.
4. Authority of the commission to provide and finance services through various mechanisms and to borrow money from private sources for such, if needed.
5. If the Regional Commission has entered into a managed care contract(s) or any such arrangement affecting more than one region, written prior approval by the DMH of such contract/arrangement before its initiation and annually thereafter.
6. If the Regional Commission provides facilities and services on a discounted or capitated basis, when such action affects more than one region, written prior approval by the DMH of such provision before its initiation and annually thereafter.
7. If the Regional Commission enters into contracts, agreements or other arrangements with any person, payer, provider or other entity, pursuant to which the regional commission assumes financial risk for the provision or delivery of any services, when such action affects more than one region, written prior approval by the DMH of such provision before its initiation and annually thereafter.
8. If the Regional Commission provides direct or indirect funding, grants, financial support and assistance for any health maintenance organization, preferred provider organization or other managed care entity or contractor (which must be operated on a nonprofit basis), when such action affects more than one region, written prior approval by the DMH, of such action before initiation and annually thereafter.
9. If the Regional Commission forms, establishes, operates and/or is a member of or participant in any managed care entity (as defined in Section 83-41-403(c) of the

Mississippi Code of 1972, Annotated, as amended), when such action affects more than one region, written prior approval by the DMH, of such action before initiation and annually thereafter.

10. At a minimum, an annual meeting by representatives of the Regional Commission and/or Community Mental Health Center with the Board of Supervisors of each county in its region for the purpose of presenting the region's total annual budget and total services system;
11. Efforts to provide or provision of alternative living arrangements for persons with serious mental illness, including, but not limited to, supervised living services.

Source: Section 41-19-33 of the *Mississippi Code, 1972, as amended*

Rule 8.4 Policies and Procedures Manual

A. The provider must have and comply with written Policies and Procedures Manual(s) which addresses all applicable administrative rules and standards in Title 24 Mental Health, Part 2 of the MS Administrative Code for all services provided. These written policies and procedures must give details of provider/agency implementation and documentation of the DMH Operational Standards for MH/IDD/SUD Community Service Providers so that a new employee or someone unfamiliar with the operation of the program would be able to carry out the duties and functions of their position and perform all operations required by the organization, its services and programs.

B. The policies and procedures manual must:

    1. Be reviewed at least annually by the governing authority, as documented in the governing authority meeting minutes
    2. Be readily accessible to all staff, with a copy at each service delivery location
    3. Describe how the manual is made available to the public.

C. The policies and procedures manual must be updated as needed, with changes approved by the governing authority before they are instituted, as documented in the governing authority meeting minutes. Changed sections, pages, etc., must show the date approved/revised on each page. Staff being affected by changes to the policies and procedures must review applicable changes. This review must be documented.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 8.5 Annual Operational Plans

A. Annual Operational Plans must be submitted by the Chairperson of the Regional Commission or Chairperson of the Governing Authority and the Executive Director of the agency to DMH by July 1 of each year by all DMH/C Providers, DMH/D Providers, and DMH/P Providers.

B. Annual Operational Plans for DMH/C, DMH/D, and DMH/P Providers that provide all or components of the core services (as identified in Rule 3.1 for DMH/C and DMH/P) must address the following:

1. The core services provided by the agency;
2. The geographical area in which core services are provided. Identified by each service and county;
3. Projected funding by major funding source (federal, state and local) for each core service;
4. The core services that the agency does not intend to provide;
5. Any other services outside of the core services being provided by the agency;
6. The geographical area in which services outside of the core services are provided. Identified by each service and county; and
7. Projected funding by major funding source (federal, state and local) for each service being provided outside of the core services.

C. DMH will approve or disapprove the Annual Operational Plan based on required standards and core services established by the Department. DMH will notify the provider in writing of approval/disapproval of the Annual Operational Plan.

D. If DMH finds deficiencies in the plan based on standards and core services required for certification, DMH shall give the provider a six (6) month probationary period to bring practices and services up to the established standards and required core services.

E. If after the six (6) month probationary period, DMH determines the provider still does not meet the standards and required core services for certification, DMH may remove the certification of the provider. The provider will then be ineligible for state funds from Medicaid reimbursement or other funding sources for those services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 9: Quality Assurance

A. Providers must put in place quality management strategies that at a minimum:

1. Allow for the collection of performance measures as required by DMH;
2. Develop a Quality Management Committee with responsibility for the oversight of collection and reporting of DMH required performance measures, written analysis of serious incidents, periodic analysis of DMH required client level data collection, review of agency wide Recovery and Resiliency Activities and oversight for the development and implementation of DMH required plans of compliance.
3. Collect demographic data to monitor and evaluate cultural competency and the need for Limited English Proficiency services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 10: Fiscal Management

Rule 10.1 Compliance

All DMH Certified Providers, regardless of type, must follow the rules and procedures outlined in this Chapter. Compliance with the rules in this section will be reviewed by the DMH Fiscal Auditors.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.2 Annual Budget

A. The provider must prepare and maintain annually a formal, written, program-oriented budget of expected revenues and expenditures for the program that must:

    1. Categorize revenues for the program by source;
    2. Categorize expenses by the types of services or program components provided, and/or by grant funding; and
    3. Account for federal funds separately in accordance with the Single Audit Act of 1984.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.3 Fiscal Management System

A. The fiscal management system must:

    1. Produce monthly financial reports that show the relationship of budget and expenditures, including both revenues and expenses by category, providing assurance that budgeted amounts in grants with DMH (if applicable) are not exceeded;
    2. Provide monthly financial reports to the certified provider's governing authority and Executive Director as documented in Board minutes;
    3. Provide for the control of accounts receivable and accounts payable; and for the handling of cash, credit arrangements, discounts, write-offs, billings, and, where applicable, individual accounts; and
    4. Provide evidence that all generated income accounts are included in required fiscal audits.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.4 Financial Statements

A. Audited financial statements must be prepared annually by an independent Certified Public Accountant or, for state agency operated programs, the State Auditor's Office.

B. These financial statements:

1. Must include all foundations, component units, and/or related organizations.
2. Be presented to the agency's governing authority and to the DMH upon completion, but no later than nine (9) months of the close of the entity's fiscal year. Written Requests for extensions must be submitted to the DMH Director, Bureau of Administration to prevent interruptions in grant funding (if applicable).
3. Be in accordance with the Single Audit Act of 1984 (Office of Management and Budget (OMB) Circular A-133) for facilities which have expended $500,000 (or current threshold amount set by the Federal Office of Management and Budget) or more in Federal Financial Assistance (Detailed in Appendix 1 of the DMH Service Provider's Manual which can be found at www.dmh.ms.gov.).
4. Include a management letter describing the financial operation of the certified provider.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.5 Accounting Systems

A. Providers must develop a cost accounting system that defines and determines the cost of single units of service.

B. The provider must develop an accounting system to document grant match, and funds of individuals receiving services that:

1. Consists of a general ledger, cash disbursements journal, payroll journal, cash receipts journal, or other journals serving the same purpose, which are posted at least monthly.
2. Includes proper internal controls to prevent fraud, waste and abuse, including proper segregation of accounting duties (receipt, purchasing, recording, and reporting functions) and the requirement that all checks have two authorizing signatures.
3. Ensures that adequate documentation is maintained to support all transactions, including justification to support all types of cost allocation methods utilized, invoices, cancelled checks, etc. as well as time and attendance records to support personnel costs and approved travel vouchers and receipts to support travel.
4. Ensures that written contracts signed by both authorized service provider personnel and the contractor are secured for all contractual services charged to DMH grants (other than utilities) that specifies the dates that the contract is valid as well as the services and/or duties for which the service provider is purchasing.
5. Ensures that Federal funds are expended in accordance with the applicable federal cost principles (OMB Circular A-122 for independent, non-profits and OMB Circular A-87 for State and local governments) and that all funds are expended in accordance with guidelines outlined in the DMH Service Provider's Manual.
6. Ensures that all accounting and financial personnel adhere to the ethical standards of their profession and that provides for appropriate training of accounting and financial staff to prevent misuse of program and funds of individuals receiving services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.6 Purchasing

A. The certified provider must develop and adhere to purchasing policies and procedures that ensure:

1. Proper internal controls over the procurement, storage, and distribution functions are in place and in accordance with federal and state regulations, including proper oversight and segregation of duties between the purchasing, receiving, and recording functions.
2. Regional Mental Health Centers and state agency operated programs adhere to the laws and regulations published by the State of Mississippi Department of Finance and Administration (DFA) Procurement Manual. These regulations can be found on DFA's website (www.dfa.state.ms.us).
3. The provider maintains adequate documentation to support all purchasing transactions (e.g. requisitions, bids, purchase orders, receiving reports, invoices, canceled checks and contracts).
4. The provider maintains an inventory system accounting for all grant purchased equipment that includes a master listing of all equipment with, at a minimum, the serial number of the equipment item, the cost of the equipment item, the date that the item was purchased, the grant funded program for which the item was purchased, and the unique inventory number assigned to the item by the facility. A label with this unique inventory number must be affixed to the equipment item.
5. The provider reports to DMH all grant equipment purchases and deletions on form DMH-101-01. The DMH-101-01 form and instructions are included in the DMH Service Providers Manual.
6. Ensure that written approval is obtained from DMH and/or the county board of supervisors, depending on the source of funding, before disposition of real and personal property purchased with state and/or county appropriated funds.
7. Ensure that all insurance proceeds or proceeds from the sale of grant inventory be returned to the program for which it was initially purchased.
8. Property and equipment ledgers are periodically reconciled to general ledger accounts.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.7 Policies

A. The fiscal management system of the provider must include a fee policy that:

1. Maintains a current written schedule of rate, charge, and discount policies.
2. Is immediately accessible to individuals served by the program.
3. For community living programs, includes the development, and result in documentation, of a written financial agreement with each individual or parent/ legal

representative (of individuals under 18 years of age) entering the program that, at a minimum:

(a) Contains the basic charges agreed upon, the period to be covered by the charges, services for which special charges are made, and agreements regarding refunds for any payment made in advance;
(b) Is prepared prior to or at the time of admission and signed by the individual/parent/legal representative and provided in two (2) or more copies, one (1) copy given to the individual/parent/legal representative, and one (1) copy placed on file in the individual's record; and
(c) Does not relieve the provider of the community living program of the responsibility for the protection of the individual and personal property of the individual admitted to the program for care.

B. All providers must have policies that include/address the following:

1. Non-discrimination based on ability to pay, race, sex, age, creed, national origin or disability;
2. A sliding fee scale;
3. A method of obtaining a signed statement from the individual receiving services indicating that the individual's personal information provided is accurate;
4. All personnel who handle program funds must be bonded to cover risks associated with employee dishonesty or theft; and
5. Insurance that includes liability, fire, theft, disaster and workman's compensation must be obtained and kept current by the provider (unless otherwise provided by law).

C. All ID/DD Waiver providers must have rental/lease/sublease agreements with individuals residing in provider owned living arrangements. These agreements must afford individuals the same rights as the Landlord/Tenant Laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to125 and §89-8-1 to 89-8-1 to 89).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 10.8 Community Mental Health Centers (DMH/C Providers)</u>

Community Mental Health Centers must submit a plan to DMH when the Regional Commission and/or related organization has accumulated excess surplus funds in excess of 1/2 its annual operating budget stating the capital improvements or other projects that require such surplus accumulation. If the required plan is not submitted within forty-five (45) days of the end of the applicable fiscal year, DMH shall withhold all state appropriated funds from such regional commission until such time as the capital improvement plan is submitted. If the plan is submitted, but not accepted by DMH, the surplus funds will be expended by the regional commission in the local mental health region on housing options for the mentally ill, intellectually/developmentally disabled, substance abusers, children or other mental health or intellectual/developmental disabilities services approved by DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.9 Generated Income

A. Accounting records must be maintained on generated income from work contracts that detail dollar amounts and fund utilization.

B. The provider must maintain evidence of prior written authorization from the Director of the Bureau of Intellectual/Developmental Disabilities for utilization of generated income for anything other than supplies needed for subcontracts/products and individual wage payments. The use of generated income must be documented as: enhancing/enriching the program and not being used as part of a required match.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 11: Human Resources

Rule 11.1 Personnel Policies and Procedures

A. The provider must have written personnel policies and procedures that at a minimum:

   1. Assure that the hiring, assignment, and promotion of employees shall be based on their qualifications and abilities without regard to sex, race, color, religion, age, irrelevant disability, marital status, or ethnic or national origin
   2. Prohibit pre-employment inquiries about the nature of an applicant's disability which does not affect their ability to perform the job
   3. Prohibit an employee's salary and work time from being allocated among multiple DMH grants, and potentially among multiple grant recipients, unless approved by DMH in writing. Requests for approval must not exceed one full time equivalent (FTE) position.

B. The written personnel policies must describe personnel procedures addressing the following areas:

   1. Wage and salary administration
   2. Employee benefits
   3. Working hours
   4. Vacation and sick leave (includes maternity leave)
   5. Annual job performance evaluations. Job performance evaluations must be in writing, and there must be documented evidence that evaluations are reviewed with the employee
   6. Suspension or dismissal of an employee, including the employee appeal process
   7. Private practice by program employees
   8. The utilization (if applicable and certified to do so) of consumers and family members to provide Peer Support Services.

C. Designate staff, with documentation in their respective job description(s), to implement and/or coordinate personnel policies and procedures and to:

   1. Maintain personnel records;
   2. Disseminate employment information to program staff; and
   3. Supervise the processing of employment forms.

D. If a provider uses volunteers, there must be policies and procedures describing, at a minimum, the following:

   1. The scope and objectives of the volunteer service (role and activities of volunteers);
   2. Supervision of volunteers by staff member in areas to which volunteers are assigned.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.2 Personnel Records

A personnel record for each employee/staff member and contractual employee, as noted below, must be maintained and must include, but not be limited to:

A. The application for employment or resume, including employment history and experience;

B. A copy of the employee's degree and/or transcript;

C. A copy of the current Mississippi license or certification for all licensed or certified personnel;

D. A copy of a valid driver's license and insurance for all designated drivers;

E. For all staff and volunteers, documentation must be maintained that a criminal records background check (including prior convictions under the Vulnerable Adults Act) and child registry check (for staff and volunteers who work with or may have to work with children) has been obtained by the current entity seeking to employ the individual and no information was received that would exclude the employee/volunteer. (See Sections 43-15-6, 43-20-5, and 43-20-8 of the *Mississippi Code of 1972, Annotated*.) For the purposes of these checks, each employee/volunteer must be fingerprinted and fingerprints must be run as a part of the background check. Criminal Records background checks and child registry checks must be completed at least every five (5) years for employees hired after the effective date of the standards while the staff is employed with the agency.

F. Documentation of verification of at least two (2) references. One reference must be a professional reference.

G. Annual job performance evaluations.

H. Job description.

I. Date of hire.

J. If contractual services are provided by a certified provider, or obtained by a certified provider, there must be a current written contractual agreement in place that addresses, at minimum, the following:

1. Roles and responsibilities of both parties identified in the agreement
2. Procedures for obtaining necessary informed consent, including consent for release and sharing of information
3. Assurances that DMH Operational Standards will be met by both parties identified in the agreement.

4. An annual review of the contractual agreement by both parties.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.3 General Qualifications

To ensure initial and continuing receipt of certification/funding from the DMH or other approved sources, the provider must maintain documentation that staff meets the following qualifications unless otherwise specified herein:

A. One full-time Executive Director who has a minimum of a Master's degree in a mental health or related field with a minimum of three (3) years administrative experience in programs related to mental health, intellectual/developmental disabilities, or substance use disorders services and/or programs OR a minimum of a Bachelor's degree in nursing and current licensure as a Registered Nurse (RN) for DMH/H Providers only that primarily serve as providers of In-Home Nursing Respite Services and Home and Community Supports.

B. Director(s) with overall responsibility for a service, service area(s) (such as Community Services Director, Director of Community Support Services, Director of ID/DD Waiver Support Coordination, Program Director for Adult and Children's Partial Hospitalization, Day Treatment, Treatment Foster Care) or multiple services provided at/from a single location must have at least a Master's degree in mental health or intellectual/developmental disabilities, or a related field and either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the service and population being served). A Registered Nurse may be employed as the Director for DMH/H Providers only that primarily serve as providers of In-Home Respite and Home and Community Supports.

C. In addition to the requirements outlined in Rule 11.3, B. Directors of Treatment Foster Care Programs must also have at least one (1) year of experience in administration or supervision of a mental health or related program/service.

D. Supervisor(s) with predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services at a single location for such areas as Psychosocial Rehabilitation Services, Day Support Services etc., must have at least a Bachelor's degree in a mental health, intellectual/developmental disabilities, or a related field, and be under the supervision of an individual with a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the service and population being served).

E. Medication evaluation and monitoring, the initial evaluation, prescribing of medications, and regular/periodic monitoring of the therapeutic effects of medication prescribed for mental health purposes are provided by:

   1. A Board-certified or Board-eligible psychiatrist licensed by the Mississippi Board of Medical Licensure
   2. A psychiatric/mental health nurse practitioner licensed by the Mississippi Board of Nursing or
   3. If documented efforts, including efforts to work with the Department of Health to recruit a licensed psychiatrist through the J-I Visa or Public Health Service Program during the certification period are unsuccessful, psychiatric services may be provided by other physician(s) licensed by the Mississippi Board of Medical Licensure.

F. Medical services are provided by a psychiatrist or other physician licensed by the Mississippi Board of Medical Licensure.

G. Nursing services are provided by a Registered Nurse licensed to practice in Mississippi or a Licensed Practical Nurse as allowed in the Mississippi Nursing Practice Act and Rules and Regulations.

H. Psychological services are provided by a psychologist licensed by the Mississippi Board of Psychology.

I. Therapy or Counseling services are provided by an individual with at least a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disabilities Therapist, or Addictions Therapist (as appropriate to the service and population being served).

J. In addition to the requirements outlined in Rule 11.3.I, the Mental Health Therapist in Treatment Foster Care programs, must have at least one (1) year of experience and/or training in working directly with children/youth with behavioral/emotional disturbance.

K. All Day Treatment Specialists providing Day Treatment Services for children and youth must have a Master's degree in a mental health or related mental health field and (1) a professional license or (2) a DMH credential as a Mental Health Therapist.

L. Therapeutic Services provided as a component of an Adolescent Offender Program (AOP) can be provided by an individual with a Master's Degree in a mental health or related field (to include criminal justice) and a DMH credential as a Mental Health Therapist with designation and scope of practice limited to AOP.

M. Community Support Services are provided by an individual with at least a Bachelor's Degree in a mental health, intellectual/developmental disabilities, or related field and at least a DMH Community Support Specialist Credential. Community Support Services can also be provided by DMH Credentialed Therapists (MH, IDD and Addictions as

appropriate to the population being served) and individuals with an appropriate professional license.

N. Therapeutic Foster Care Specialist(s) must have at least a Bachelor's Degree in a Mental Health or related field and at least one (1) year of documented experience and/or training in working with children with special behavioral/emotional needs and their families/other caregivers.

O. Teachers and Education Specialists have a Master's degree or a Bachelor's degree in Special Education, as required, with training in mental health, intellectual/developmental disabilities, or a related field, and possess certification by the MS Department of Education appropriate to the service area for which they are assigned.

P. All staff providing Peer Support Services (i.e. Certified Peer Specialist) must possess at least a high school diploma or GED equivalent, self-identify as a current or former consumer of mental health services, or self-identify as first degree family member, parent or primary caregiver. For young adults ages sixteen to twenty (16-20) years, peer support specialists must be enrolled and attending school or in the process of obtaining a Test of General Education Development (GED). All staff must successfully complete the DMH approved Certified Peer Specialist training and certification exam to become a Certified Peer Support Specialist.

Q. Wraparound Facilitators must hold a minimum of a Bachelor's Degree in a mental health, intellectual/developmental disabilities, or related field complete the "Introduction to Wraparound" 3-day training and subsequent trainings. Wraparound Facilitators must be under the supervision of a Master's level staff who has also completed the "Introduction to Wraparound" 3-day training.

R. All direct care staff such as Aides, House Parents, House Managers, On-Site Community Living Managers, Direct Care Workers, Direct Support Professionals, Work Trainers, Production Assistants, Day Treatment Assistants, support staff in Psychosocial Rehabilitation, Senior Psychosocial, and Day Support Programs, Day Services-Adult staff, Home and Community Support Services staff, Job Coaches, etc. must have at least a high school diploma or equivalent (GED).

S. All support staff (responsible for indirect services to individuals receiving services) such as Secretary, Bookkeeper, Office Clerk, Cook, etc., must have any combination of education and experience which is acceptable to the certified provider, and is equivalent to a high school diploma or GED.

T. Specialists such as Audiologists, Speech/Language Pathologists, Occupational Therapists, Dieticians, Physical Therapists, etc., must meet the educational requirements of and be licensed by their respective licensing authority in Mississippi.

U. Individuals serving as Qualified Intellectual Disabilities/ Professionals (QIDP) must have at least a Bachelor's degree in a human services field and one year of experience in direct service with individuals with developmental disabilities.

V. Individuals writing Job Discovery Profiles for IDD Waiver Services must have at least a Bachelor's Degree in a mental health/ intellectual/developmental disabilities, or related field, and be under the supervision of an individual meeting the requirements of Rule B. Individuals writing Job Discovery Profiles must have completed training in Customized Employment approved by the DMH prior to service provision. Observation and/or participation in Job Discovery activities can be conducted by direct care staff meeting the requirements of 11.3.S.

W. Family members are prohibited from providing services to another family member with the exception of Home and Community Supports, In-Home Respite, and Host Home Services.

Y. Targeted case management for individuals with SMI or SED must be provided by, at a minimum, a licensed social worker (LSW) with two (2) years of experience in mental health, a registered nurse (RN) with two (2) years of experience in mental health, or an individual who meets the qualifications to provide therapy or counseling services as stated in letter I above.

Z. Targeted case management for individuals with IDD must be provided by a Licensed Social Worker (LSW) or an individual with at least a Bachelor's Degree in an intellectual/developmental disabilities, or related field; meet the requirements of a Qualified Intellectual Disabilities Professional (QIDP) as well as having at least two (2) years of experience working with people with IDD and have completed the required Person Centered Planning training (both Person Centered Thinking and Person Centered Facilitation) as set forth by the DMH prior to becoming responsible for the development of the Plan of Services and Supports.

AA. ID/DD Waiver Support Coordination is provided by an individual with at least a Bachelor's Degree in an intellectual/developmental disabilities, or related field. Support Coordination can also be provided by DMH Credentialed Therapists, as appropriate to the population being served or individuals with an appropriate professional license. ID/DD Waiver Support Coordination can also be provided by a Registered Nurse with at least one (1) year of experience working with people who have intellectual/developmental disabilities.

BB. All individuals providing Supported Employment Services to individuals with a serious mental illness must have, at a minimum, a Bachelor's Degree in mental health, vocational rehabilitation, social services or business. Individuals must be proficient or receive training in the development of a career profile, employment plans, job development, career development, job search and Social Security benefits.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.4 Qualifications for Behavior Support and Crisis Intervention Provided through the ID/DD Waiver

A. ID/DD Waiver Behavior Consultants must be a Licensed Psychologist, Licensed Professional Counselor, Licensed Certified Social Worker, Board Certified Behavior Analyst ®, or have a Master's degree in a field related to working with individuals with intellectual and developmental disabilities who require behavior support and have at least two (2) years of documented experience conducting Functional Behavior Assessments and developing and implementing Behavior Support Plans. The Behavior Consultant must hold at least a CMHT or CIDDT DMH credential. The Behavior Consultant must be Mandt certified or hold another nationally recognized credential approved by DMH.

B. ID/DD Waiver Behavior Interventionists must have at least a Bachelor's Degree in a field related to working with individuals with intellectual and developmental disabilities who require behavior services and have at least two (2) years of documented experience working with individuals who have intellectual and developmental disabilities. The Behavior Interventionist must be Mandt certified or hold another nationally recognized credential approved by DMH. The Behavior Interventionist must be supervised/monitored by a Behavior Consultant (as defined in Rule 11.4 A).

C. ID/DD Waiver Crisis Intervention providers must have a team that includes:

1. A Licensed Psychologist
2. A director (as defined in Rule 11.3 B) who also has specialized training in crisis intervention The Crisis Intervention Director must be Mandt certified or hold another nationally recognized credential approved by DMH.
3. A QDDP who is under the supervision of an individual with a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has at least two (2) years of documented experience working with individuals who have intellectual and developmental disabilities. The QDDP must be Mandt certified or hold another nationally recognized credential approved by DMH.
4. Direct support staff (as defined in 11.3 S) with specialized training in crisis intervention. The direct support staff must be Mandt certified or hold another nationally recognized credential approved by DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.5 Qualifications for Providers of Substance Use Disorders Services

A. Directors/coordinators of all alcohol and drug treatment or prevention programs must have at least: (1) a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field (2) a professional license, hold a DMH credential as a Certified Mental Health Therapist or DMH Certified Addictions Therapist,

or a professional substance use disorder credential approved by DMH, and two (2) years of experience in the field of substance use disorder treatment/prevention. Staff who self-identify as in recovery must have a minimum of one (1) year of sustained recovery.

B. Support staff employed in Substance Use Disorder Residential Programs who self-identify as in recovery must have a minimum of six (6) months of sustained recovery.

C. Directors of Prevention Services must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field, and a minimum of two (2) years of experience in the treatment/prevention of substance use disorders. Staff who self-identify as in recovery, must have a minimum of one (1) year of sustained recovery.

D. Prevention Specialists must have at least a Bachelor's degree. Staff who self-identify as in recovery must have a minimum of one (1) year of sustained recovery.

E. Substance Use Disorders Outpatient Therapists including Intensive Outpatient Treatment Therapists, must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field and a (1) professional license or (2) hold a DMH credential as a Certified Mental Health Therapist or DMH Certified Addictions Therapist. Staff who self-identify as in recovery must have a minimum of one (1) year of sustained recovery.

F. All Recovery Support Staff must have at least a high school diploma or GED. These individuals must also successfully complete a substance use disorder services certification program approved by DMH within thirty-six (36) months of the date of employment. Staff who self-identify as in recovery, must have a minimum of six (6) months of sustained recovery.

G. Residential Program counseling staff must have at least a Bachelor's degree in a mental health or a related behavioral health field. These individuals must also successfully complete a substance use disorders certification program approved by DMH within thirty-six (36) months of the date of employment. Staff who self-identify as in recovery, must have a minimum of one (1) year of sustained recovery.

H. Providers certified as DMH/C that provide Medicaid-reimbursed services: individual therapy, family therapy, group therapy, multi-family therapy and Individual Service Plan review to individuals with a substance abuse diagnosis must have at least a Master's degree in a mental health or related behavioral health field and (1) have a professional license or (2) a DMH credential as a Mental Health Therapist or (3) DMH credentials as Certified Addictions Therapist.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.6 Qualifications for Programs of Assertive Community Treatment (PACT)

A. Team Leader: The team leader must have at least a Master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatrist. The team leader must be professionally licensed or have DMH credentials as a Certified Mental Health Therapist.

B. Psychiatrist/Psychiatric Nurse Practitioner: A psychiatrist/psychiatric nurse practitioner, who work on a full-time or part-time basis, must meet applicable licensure requirements of state boards.

C. Registered Nurse: The registered nurse must be licensed and in good standing with the MS Board of Nursing.

D. Master's Level Mental Health Professionals: Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with severe and persistent mental illness. They are licensed or certified and operate under the code of ethics of their professions. Mental health professionals include persons with Master's or Doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; Diploma, Associate, and Bachelor's degree nurses (i.e., registered nurse); and registered occupational therapists.

E. Substance Use Disorders Specialist: A mental health professional with training and experience in substance use disorders assessment and treatment.

F. Employment Specialist: A mental health professional with training and experience in rehabilitation counseling.

G. Peer Specialist: At least one FTE Certified Peer Support Specialist. Peer Support Specialists must be fully integrated team members.

H. Remaining Clinical Staff: The remaining clinical staff may be Bachelor's level and paraprofessional mental health workers. A Bachelor's level mental health worker has a Bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A paraprofessional mental health worker may have a Bachelor's degree in a field other than behavioral sciences or have a high school diploma and work experience with adults with severe and persistent mental illness or with individuals with similar human-service needs. These paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

I. Program Assistant: Assistants must have at least a high school diploma or a GED and be at least twenty-one (21) years old.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.7 Multidisciplinary Staff at DMH/C and DMH/P Providers)

Community Mental Health Center providers (certified under the DMH/C option) and other community mental health service providers certified as DMH/P providers must have a multidisciplinary staff, with at least the following disciplines represented:

A. A psychiatrist who is board certified or board eligible and licensed to practice medicine in Mississippi. (Available on a contractual, part-time or full-time basis).

B. A psychologist licensed to practice in Mississippi (available on a contractual, part-time or full-time basis).

C. A full-time or full-time equivalent registered nurse.

D. A full-time or full-time equivalent Licensed Master Social Worker, Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT).

E. A full-time or full-time equivalent business manager who is capable of assuming responsibility for the fiscal operations of the program.

F. A full-time or full-time equivalent records practitioner or designated records clerk who is capable of assuming responsibility for the supervision and control of all center records.

G. An individual with at least a Master's degree in a mental health or related field on a full-time basis to supervise children's mental health services. This person must have administrative authority and responsibility for children's mental health services. This person cannot have any direct service responsibilities.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 12: Training/Staff Development

Rule 12.1 General Orientation

A. All new employees and volunteers/interns must attend a General Orientation program developed by the agency or receive the orientation information via a DMH approved on-line training program (such as Essential Learning or the College of Direct Support). General Orientation must be provided/completed within thirty (30) days of hire/placement, except for direct service providers and direct service interns/volunteers. All direct service staff must complete all required orientation prior to contact with individuals receiving services and/or service delivery.

B. At a minimum, General Orientation must address the following areas:

1. Overview of the agency's mission and an overview of the agency policies and procedures
2. DMH Operational Standards (as applicable to services provided)
3. DMH Record Guide and Record Keeping (as applicable to services provided)
4. Basic First Aid
5. CPR
6. Infection Control
   (a) Universal Precautions
   (b) Hand-washing
7. Workplace Safety
   (a) Fire and disaster training
   (b) Emergency/disaster response
   (c) Serious incident reporting
   (d) Reporting of suspected abuse/neglect (including signed acknowledgement of reporting responsibilities)
8. Rights of Individuals Receiving Services
9. Confidentiality
10. Family/Cultural Issues and Respecting Cultural Differences
11. Basic standards of ethical and professional conduct
    (a) Drug Free Workplace
    (b) Sexual Harassment
    (c) Acceptable professional organization/credentialing standards and guidelines as appropriate to discipline (i.e., ACA Code of Ethics, Social Work Code of Ethics, APA Ethics Code) - *Direct service providers only*
12. Principles of positive behavior support
13. Principles of behavior support (physical and verbal)

C. In addition to the requirements of 12.1 A and B, all direct service staff must be certified in CPR prior to contact with individuals receiving services and/or service delivery.

D. In addition to the requirements of 12.1 A and B, Opioid Treatment Programs must include the following in general orientation:

1. Overdose management and other emergency procedures;
2. Clinical and pharmacotherapy issues;
3. Special populations to include women and seniors;
4. Poly-drug addiction; and,
5. HIV/AIDS, TB, and other infectious diseases.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.2 Staff Training Plans

A. Providers must develop a Staff Training Plan specific to each position classification as listed below. Each Staff Training Plan must be based on job responsibilities, program/position requirements, and identified staff needs. The Staff Training Plan must be reviewed annually for changes and/or updates and should be available for review by DMH staff. Position specific training must be provided within ninety (90) days of hire and consist of a minimum of twenty (20) hours of training (medical personnel excluded – i.e., psychiatrists, nurses, etc.). The following position classifications must be addressed:

1. Direct service provider (i.e., therapist, community support specialist, program assistants)
2. Administrative/support staff (i.e., office manager, medical records technician, accounting staff)

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.3 Continuing Education Plans

A. Providers must develop an Annual Continuing Education Plan specific to each position classification as listed below. Each Continuing Education Plan should be based on job responsibilities, credentialing requirements, and identified staff needs. The Continuing Education Plan must be reviewed annually for changes and/or updates and must be available for review by DMH Staff. The following position classifications and required minimum hours of continuing education must be addressed:

1. Direct service provider (i.e., community support specialist, program assistants). A minimum of thirty (30) continuing education hours every two (2) years must be completed by all individuals in this position class.
   (a) IDD direct service providers who do not hold a license or DMH Credential, a minimum of fifteen (15) hours per year of continuing education is required.
2. DMH Credentialed Therapists must complete a minimum of thirty (30) continuing education hours every two (2) years.

3. Professionally licensed staff (i.e., Psychologists, social workers, etc.) must adhere to the continuing education requirements of their respective state licensing boards.
4. Administrative/support staff (i.e., office manager, medical records technician, accounting staff).
5. Medical personnel (i.e., psychiatrist, nurses) - as required by state licensing boards.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.4 Required Components of Staff Training Plans and Continuing Education Plans

A. At a minimum, Staff Training Plans and Continuing Education Plans must address the following areas:

1. Crisis intervention and prevention
2. Continued CPR Certification for all direct service staff
3. Person Centered, Recovery Oriented Systems of Care Mental Health Providers and Substance Use Disorders Providers)
4. Person-Centered Planning Intellectual/ Developmental Disabilities Providers)
5. Concepts of Wraparound Service Delivery Children and Youth Mental Health Providers)
6. Accurate gathering, documentation and reporting of data elements outlined in the current version of the DMH's Manual of Uniform Data Standards for staff responsible for data collection and entry.
7. Positive behavior support concepts (as applicable to the population being served)

B. All staff is required to participate in orientations, program/position specific training, staff development opportunities, and other meetings as required by DMH for their position specification.

C. Documentation of training that individual staff has received must be included in individual training and/or personnel records. This documentation can include certificates of completion for DMH approved on-line learning. If training is provided in person or through other means, the documentation must include:

1. Name of training
2. Instructor's name and credentials
3. Date of training
4. Length of time spent in training
5. Topics covered

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.5 Skills and Competencies

A. For staff working with individuals receiving services, orientation, training and continuing education must focus on skills and competencies directed towards the intellectual, developmental, behavioral and health needs of the individuals being served.

B. For all staff working with individuals receiving services in all day programs and in all residential community living programs, training and certification in a nationally recognized and DMH approved technique for managing aggressive or risk-to-self behaviors to include verbal and physical de-escalation is required. (This does not apply to Alzheimer's Day Services.)

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 13: Health and Safety

Rule 13.1 Compliance

All DMH Certified Providers, regardless of type, must follow the rules and standards outlined in this Chapter. Supported Living, Supervised Living, Shared Supported Living and Host Homes programs that are not owned/operated by a certified provider are exempt from some or all of the procedures and standards outlined in this part as noted. Additionally, Therapeutic Foster Care Programs and Therapeutic Group Homes licensed by the MS Department of Human Services are exempt from the rules outlined in this Chapter.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.2 Local Fire, Health and Safety Codes

A. All programs must meet state and local fire, health, and safety codes with documentation maintained at each site, as follows:

   1. Each program site must be inspected and approved by appropriate local and/or state fire, health and safety agencies at least annually (within the anniversary month of the last inspection), and there must be written records at each site of fire and health inspections. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

   2. Safety inspections conducted by reputable fire safety agencies are permissible only for community living program settings in lieu of local or state inspection(s). (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

   3. Crisis Stabilization Units and Primary Substance Abuse Rehabilitation and Treatment Programs with certified capacities of sixteen (16) or more participants shall obtain a Food Service Permit from the Mississippi State Department of Health.

   4. Crisis Stabilization Units and Primary Substance Abuse Rehabilitation and Treatment Programs with certified capacities of sixteen (16) or more participants shall meet the requirements as set forth in the Residential Inspection Report issued by the Mississippi State Department of Health.

   5. Documentation by appropriate fire and health authorities that noted citations have been corrected must be maintained at each site. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

   6. Program~~s~~ sites with an existing sprinkler system must have annual inspection by a licensed company or the local fire authorities. There must be documentation of

annual inspection by a licensed company. (Exclusion: Supported Living programs that are not owned/operated by an agency or certified provider, Shared Supported Living programs and Host Homes.)

7. Each program site must provide evidence and documentation of a systematic pest control program. This documentation must be maintained at each site. For apartment settings, the provider must show documentation that the apartment complex provides pest control. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

8. Each program site must have an established method of scheduled fire equipment inspection that includes: (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

   (a) An annual inspection by an outside source (i.e., fire marshal, fire department representative, fire/safety company) that results in a dated tag on each piece of equipment inspected; and

9. Each program site must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the facility/home, and document that all fire extinguishers are properly maintained and serviced. Facilities/homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

10. Each program site must have, at minimum, operable fire extinguishing equipment and alarms/detectors located throughout the site in all areas where conditions warrant (i.e., flammable storage areas, kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

11. Each program site must have, at a minimum, operable carbon monoxide detectors located in any building where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.3 Exits

A. Diagrams of escape routes must be easy to read from a short distance and posted in highly visible locations throughout the environment, clearly indicating where a person is located in relation to the nearest exit(s). In lieu of posted escape routes, providers of Supervised Living, Supported Living, Shared Supported Living, and Host Home

Services, must document training that prepare an individual to exit the location in the event of emergency. Training must take place upon admission and at least quarterly thereafter. This documentation must be maintained on site.

B. Every exit shall be clearly visible, or the route to reach every exit shall be conspicuously indicated. Each means of egress, in its entirety, shall be arranged or marked so that the way to a place of safety is indicated in a clear manner. (Exclusion: Supervised Living, Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

C. Two (2) means of exit per service area must be provided which are readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

D. Exits must be marked by a lighted sign with lettering, at a minimum, six (6) inches in height on a contrasting background in plain lettering that is readily visible from any direction of exit access (excludes Supervised, Supported Living, and Host Home Services). The signs must be lighted at all times. The illuminated lights must have battery backup in order to be readily visible in the event of electrical failure (facilities with backup generator systems are excluded from the battery backup requirement. (Exclusion: Supervised Living, Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

E. Any accessible window(s) must be operable from the inside without the use of tools and must provide a clear opening of not fewer than twenty (20) inches in width and twenty-four (24) inches in height (with the exception of CSUs and Supported Living, Shared Supported, and Host Homes sites that are not owned/operated by a certified provider).

F. No door in any path of exit, or the exit door itself, may be locked when the building is occupied unless an emergency system is in place that will allow the door to unlock in an emergency (Exclusion: Supporting Living Services that are not owned/operated by a certified provider, Supervising Living, Shared Supported Living, and Host Home Services).

G. Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (Exclusion: Supporting Living Services that are not owned/operated by a certified provider, Shared Supported Living, Supervised Living, and Host Home Services):

1. A readily visible, durable sign in letters not less than one (1) inch high on contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED
2. The locking device is one that is readily distinguishable as locked.

3. Each staff member inside the building must have a key on their person when the egress door is locked.
4. There may only be one locked door per means of egress.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.4 Safe and Sanitary Conditions

A. The interior and exterior of each program must be maintained in a safe and sanitary manner. Furnishings must be kept clean, well-kept and in good repair.

B. All programs must have operable hot water. The water temperature in all water heaters in facilities providing services directly to individuals enrolled in DMH programs must be set at no higher than one hundred twenty degrees (120 degrees) Fahrenheit and no lower than one hundred (100) degrees Fahrenheit. (Exception: Supported Living and Host Homes.)

C. Emergency lighting systems (appropriate to the setting) must be located in corridors and/or hallways and must provide the required illumination automatically in the event of any interruption of normal lighting such as failure of public utility or other outside power supply, opening of a circuit breaker or fuse, or any manual act which disrupts the power supply. (Exception: Supervised Living, Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

D. All DMH certified service locations must conduct a Safety Review of the premises on a monthly basis. A Safety Review Log must be completed and kept on site. Staff must date and initial when each item on the Safety Review Log has been checked. The Safety Review Log must include;

1. All fire extinguishers. Staff is to verify each extinguisher is properly charged and mounted. Each extinguisher must be listed separately by location in the facility and include the serial number. Fire extinguishers mounted in agency vehicles are to be included in the review.
2. All fire/smoke detectors. Staff is to verify each detector is working properly by testing the audible signal. Each detector is to be listed separately by location in the facility.
3. All carbon monoxide detectors (if applicable.) Staff is to verify each detector is working properly by testing the audible signal. Each detector is to be listed separately by location in the facility.
4. Lighted exit signs. Staff is to verify each sign is working properly by interrupting the power supply to the sign. Each sign is to be listed separately by location in the facility.
5. Hot water fixtures. Staff is to verify the hot water at each fixture in the facility measures between 100 and 120 degrees Fahrenheit. Each fixture is to be listed separately by location in the facility.

6. Emergency lights. Staff is to verify each emergency light is working properly by interrupting the power supply to the light for at least thirty (30) seconds. Each emergency light is to be listed separately by location in the facility.
7. Safe and sanitary conditions. Staff is to verify the program's environment is safe and sanitary through visual inspection.

E. Any program that has a kitchen used by individuals receiving services must be designed and equipped to facilitate preparing and serving meals in a clean and orderly fashion. At a minimum, the following equipment must be provided: (Exception: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

1. Two-compartment sink or an automatic dishwasher and single sink (Except in single occupancy living situations, in which case a single compartment sink is acceptable)
2. Adequate supply of dishes, cooking utensils, etc.
3. Adequate refrigeration facilities
4. Adequate space for the storage of food supplies. (No food supplies may be stored on the floor.)
5. Approved fire extinguishing equipment and alarms/smoke detectors which show evidence of fire department inspection placed strategically to allow detection of smoke/fire in the kitchen.

F. Restroom door locks must be designed to permit the opening of the locked door from the outside. (Exception: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

G. All supplies, including flammable liquids and other harmful materials, must be stored to provide for the safety of the individuals receiving services and the staff working in the program.

H. Each program must provide floor space for the lounge/dining/visitation area(s) that is easily accessed/exited in case of emergency.

I. All programs must have operational utilities (water/sewer, air conditioning/heat, electricity).

I. Each site must have a written plan of action in place in case utilities fail. The plan must be readily available for review. (Exception: Supported Living, Shared Supported programs that are not owned/operated by a certified provider and Host Homes.)

J. No stove or combustion heater may be so located as to block escape in case of fire arising from a malfunction of the stove or heater.

K. No portable heaters are allowed in service areas or bedrooms.

L. DMH may require additional square footage in any program in order to accommodate the needs of the individuals in the program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.5 Accessibility

A. All program sites and services must be in compliance with Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act (P.L. 101-336).

B. For Supervised Living, Share Supported Living, and Host Homes, and based on the needs of the individuals served in each residence, the provider must make necessary modifications as outlined in 13.5 B-G and Rule 13.6. Services cannot be denied based on the need for modifications. (Exclusion: Supported Living programs that are not owned/operated by a certified provider).

C. New construction of program sites or renovation of existing locations must be in compliance with ADA requirements.

D. The clear width of doorways when the door is in the full open position must not be fewer than thirty-two (32) inches.

E. At least one restroom at the site must be accessible to individuals with physical disabilities with either one accessible restroom for each sex or one (1) accessible unisex restroom being acceptable. Additionally, day programs serving individuals with ID/DD must have adequate private changing facilities.

F. The accessible restroom stall must have grab bars behind and beside the toilet and on the wall nearest the lavatory/sink.

G. All faucets, soap and other dispensers, and hand dryers (if present) must be within reach of someone using a wheelchair and usable with one closed fist.

H. All doors, including stall doors in the restroom, must be operable with a closed fist from the inside.

I. Any program that has drinking fountains must have at least one fountain that is ADA accessible.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.6 Stairs

A. Doors opening onto stairs must have a landing, at a minimum, the width of the door.

B. Minimum head room on stairs and ramps to clear all obstructions must be six feet and eight inches (6' 8").

C. Stairs in the program sites, must have the following dimensions:

1. Stair width must be at least thirty-two (32) inches
2. Minimum tread depth of each step of the stairs must be at least nine (9) inches
3. Maximum height of risers in each step must not exceed eight (8) inches

D. Guards and handrails must be provided on both sides of all stairs and ramps rising more than thirty (30) inches above the floor or grade.

1. Guards and handrails must continue for the full length of the ramp or stairs
2. Handrails must provide at least one and one-half (1.5) inches between the inner side of the rail and support wall
3. Handrails must be located between thirty-four (34) inches to thirty-eight (38) inches above the tread of the step or ramp surfaces.

E. Steps, ramps and platforms and landing(s) associated with them must be:

1. Designed for at least one hundred (100) pounds per square foot.
2. Have a slip-resistant surface.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.7 Transportation of Individuals Receiving Services

Providers/programs providing transportation in program vehicles to individuals receiving services must meet the following criteria:

A. All vehicles and drivers must comply with the applicable laws of Mississippi regarding motor vehicle operation, licensure, maintenance, and be kept in good repair.

B. When transporting individuals receiving services, the following staff to individual ratios applies only for the stated populations below:

1. When transporting children age zero to six (0-6) years, the staff ratio in addition to the driver must be one (1) staff to five (5) children and one (1) staff to three (3) children when more than three (3) are infants or toddlers (0-24 months).

2. When transporting individuals with intellectual/developmental disabilities, there must be one (1) staff (which can be the driver) for every six (6) individuals. For seven (7) to twelve (12) individuals, there must be one staff in addition to the driver. If an individual utilizes a wheelchair an additional staff member is required.

C. The vehicle must have a securely mounted/fixed fire extinguisher with proof of annual inspection, flares or reflectors, a flashlight, and first aid kit which contains the following: gloves, adhesive bandages, gauze, first aid tape, sterile pads, antiseptic wipes, and a first aid booklet. All items must be current.

D. All vehicles must have liability insurance unless otherwise authorized by state law. Proof of insurance must be kept in the vehicle.

E. All vehicles must be equipped with a secure, operable seat belt for each passenger transported. Children must be seated in approved safety seats with proper restraint in accordance with state law.

F. Providers that provide transportation must have policies and procedures in place to protect the safety and well-being of individuals being transported. Policies and procedures must address, at a minimum:

1. Accessibility based on the individuals' needs and reasonable requests
2. Accounting of individuals entering and exiting the provider/program vehicle. This must be made available for review.
3. Availability of communication devices (i.e., cell phones, 2-way radios, etc.)
4. Availability of a vehicle maintenance log for all vehicles used to provide transportation
5. Course of action when staff is unable to leave individuals at home or an alternate site as specified by family/legal representative that ensures the safety of individuals at all times.
6. Availability of additional staff to assist with transportation if the needs of the individuals being transported warrant additional staff assistance.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 13.8 Medication Control and First Aid Kits</u>

A. Providers must have written policies and procedures and documentation of their implementation pertaining to medication control which assures that:

1. The administration of all prescription drugs and/or other medical procedures must be directed and supervised by a licensed physician or a licensed nurse in accordance with the Mississippi Nursing Practice Law and Rules and Regulations.
2. All medications must be clearly labeled. Labeling of prescription medications must also include the name of the individual for whom it was prescribed.

3. Medication prescribed for a specific individual must be discarded when no longer used by said individual and according to a written procedure to do so.
4. Adequate space is provided for storage of drugs that is well lighted and kept securely locked. (Exception: Supported Living Shared Supported, and Host Home)
5. Medication stored in a refrigerator which contains items other than drugs will be kept in a separate locked compartment or container with proper labeling. (Exception: Supported Living, Shared Supported and Host Home)
6. Drugs for external and internal use will be stored in separate cabinets or on separate shelves which are plainly labeled according to such use. (Exception: Supported Living, Shared Supported and Host Home)
7. Prescription drugs will be stored in a separate cabinet or compartment utilized only for that purpose. Prescription drugs must not be stored with nonprescription drugs. All drugs must be stored in a location utilized only for storage of prescription and nonprescription drugs. (Exception: Supported Living, Shared Supported and Host Home)
8. Transporting and delivery of medications follows any rules, regulations, guidelines, and statutes set forth by governing bodies authorized to do such.
9. Practices for the self-administration of medication by individuals served in a program are developed with consultation of the medical staff of the provider or the individual's treating medical provider(s).

B. Each site must have a first aid kit. The kit must contain gloves, adhesive bandages, gauze, first aid tape, sterile pads, antiseptic wipes, and a first aid booklet. For buildings housing more than one program, a single first aid kit may be used by all programs, if readily/easily accessible for all individuals in the building. All items must be current.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 13.9 Disaster Preparedness and Response</u>

A. An Emergency/ Disaster Response Plan must be developed and maintained for each site, information may be similar to other locations, but specific site information is required. A Continuity of Operations Plan (COOP) must be developed for each agency and a copy maintained at each site location.

B. Providers must develop and maintain an emergency/disaster response plan for each facility/program that is specific to each certified location/site, approved by the governing body, for responding to natural disasters, manmade disasters (fires, bomb threats, utility failures and other threatening situations, such as workplace violence). The plan should identify which events are most likely to affect the facility/program. This plan must address at a minimum:

1. Lines of authority and Incident Command;
2. Identification of a Disaster Coordinator;
3. Notification and plan activation;

4. Coordination of planning and response activities with local and state emergency management authorities;
5. Assurances that staff will be available to respond during an emergency/disaster;
6. Communication with individuals receiving services, staff, governing authorities, and accrediting and/or licensing entities;
7. Accounting for all persons involved (staff and individuals receiving services);
8. Conditions for evacuation;
9. Procedures for evacuation;
10. Conditions for agency closure;
11. Procedures for agency closure;
12. Schedules of drills for the plan;
13. The location of all fire extinguishing equipment, carbon monoxide detectors (if gas or any other means of carbon monoxide emission is used in facility) and alarms/smoke detectors;
14. The identified or established method of annual fire equipment inspection; and,
15. Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.

C. Providers must develop and maintain a Continuity of Operations Plan, approved by the governing body, for responding to natural disasters, manmade disasters, fires, bomb threats, utility failures and other threatening situations, such as workplace violence. This plan must address at a minimum:

1. Identification of provider's essential functions in the event of emergency/ disaster;
2. Identification of necessary staffing to carry out essential functions;
3. Delegations of authority;
4. Alternate work sites in the event of location/site closure;
5. Identification of vital records and their locations; and,
6. Identification of systems to maintain security of and access to vital records.

D. Copies of the Emergency/Disaster Response Plans and the Continuity of Operations Plan must be maintained on-site for each facility/program and at the agency's administrative offices.

E. All agencies must document implementation of the written plans for emergency/disaster response that are specific to that location/site and continuity of operations. This documentation of implementation must include, but is not limited to the following: (Exception: Host Homes, Shared Supported and Supported Living.)

1. Quarterly fire drills for day programs
2. Monthly fire drills for supervised living and/or residential treatment programs, conducted on a rotating schedule within the following time frames:
   (a) 7 a.m. to 3 p.m.
   (b) 3 p.m. to 11 p.m.
   (c) 11 p.m. to 7 a.m.

3. Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.
4. Annual drill of Continuity of Operations Plan for the agency with documentation maintained at the main office.

F. All community living, residential treatment programs, and/or Crisis Stabilization Units must maintain current emergency/disaster preparedness kits to support individuals receiving services and staff for a minimum of seventy-two (72) hours post event. At a minimum, these supplies must be kept in one place and include the following:

1. Non-perishable foods;
2. Manual can opener;
3. Water;
4. Flashlights and batteries;
5. Plastic sheeting and duct tape;
6. Battery powered radio;
7. Personal hygiene items.

G. All community living, residential treatment programs, and/or Crisis Stabilization Units must have policies and procedures that can be implemented in the event of an emergency that ensure medication, prescription and nonprescription, based on the needs of the individuals in the program and guidance of appropriate medical staff is available for up to seventy-two (72) hours post-event.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 14: Rights of Individuals Receiving Services

Rule 14.1 Rights of Individuals Receiving Services

A. There must be written and implemented policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal representative(s) is informed of their rights while served by the program, at intake and at least annually thereafter if he/she continues to receive services. These rights are applicable to all individuals receiving services except for individuals that have been civilly committed or individuals who are confined to a correctional facility. The individual receiving services and/or parent/legal representative must also be given a written copy of these rights, which at a minimum, must include:

1. The services within the program and other services available regardless of cultural barriers and limited English proficiency;

2. The right to access services that support an individual to live, work and participate in the community to the fullest extent of the individual's capability;

3. The right to services and choices, along with program rules and regulations, that support recovery/resiliency and person-centered services and supports;

4. The right to be referred to other providers services and supports in the event the provider is unequipped or unable to serve the individual;

5. The right to refuse treatment/services;

6. The right to ethical treatment including but not limited to the following:

   (a) The right not to be subjected to corporal punishment
   (b) The right to be free from all forms of abuse or harassment
   (c) The right to be free from restraints of any form that are not medically necessary or that are used as a means of coercion, discipline, convenience or retaliation by staff
   (d) The right to considerate, respectful treatment from all employees and volunteers of the provider program.

7. The right to voice opinions, recommendations, and to file a written grievance which will result in program review and response without retribution;

8. The right to personal privacy, including privacy with respect to visitors in day programs and community living programs as much as physically possible;

9. The right to not be discriminated against based on HIV or AIDS status.

10. The right to considerate, respectful treatment from all employees of the provider program;

11. The right to have reasonable access to the clergy and advocates and access to legal counsel at all times;

12. The right of the individual being served to review his/her records, except as restricted by law;

13. The right to participate in and receive a copy of the individual plan (as defined in Rule 17.1) including, but not limited to, the following:

    (a) The right to make informed decisions regarding his/her care and services, including being informed of his/her health status (when applicable), being involved in care/service planning and treatment and being able to request or refuse treatment/service(s). This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
    (b) The right to access information contained in his/her case record within a reasonable time frame. (A reasonable time frame is within five (5) days; if it takes longer, the reason for the delay must be communicated). The provider must not frustrate the legitimate efforts of individuals being served to gain access to their own case records and must actively seek to meet these requests as quickly as its record keeping system permits. MCA 41-21-102 (7) does allow for restriction to access to records in certain circumstances where it is medically contraindicated.
    (c) The right to be informed of any hazardous side effects of medication prescribed by staff medical personnel.

14. The ability to retain all Constitutional rights, except as restricted by due process and resulting court order;

15. The right to have a family member or representative of his/her choice notified promptly of his/her admission to a hospital;

16. The right to receive care in a safe setting;

17. The right to involve or not involve family and/or others is recognized and respected; and,

18. The right to engage in planning, development, delivery and the evaluation of the services an individual is receiving.

19. The right to have visitors of his/her choosing at any time, to the greatest extent possible. Visitation rights cannot be withheld as punishment or in any other manner that unreasonably infringes on the individual's stated rights;

20. The right to daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated. If restrictions to communication are put in place, the individual has the right to following:

    (a) Any restrictions on private telephone use must be reviewed daily
    (b) All actions regarding restrictions on outside communication must be documented in the individual's record
    (c) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.2 Staff Roles in Protecting Rights of Individuals Receiving Services

A. The provider must define each staff member's responsibility in maintaining an individual's rights, as well as the ability to explain these rights to the individuals receiving services or their family members/legal representatives.

B. The provider's policies and procedures must be written in such a way that staff member's roles in maintaining or explaining these rights are clearly defined.

C. The policies and procedures must also clearly explain how the provider will train staff members to develop and retain the skills needed to uphold this role. This includes specific training regarding each right and how to explain it in a manner that is understandable to the individual and/or family member/legal representative. Training must focus on the population being served, but can include other related areas for broadened understanding.

D. An individual receiving services cannot be required to do work which would otherwise require payment to other program staff or contractual staff. For work done, wages must be in accordance with local, state, and federal requirements (such as the provision of Peer Support Services by a Certified Peer Support Specialist) or the program must have a policy that the individuals do not work for the program.

E. A record of any individuals for whom the provider is the legal representative or a representative payee must be on file with supporting documentation.

F. For programs serving as conservator or representative payee, the following action must be taken for each individual:

    1. A record of sums of money received for/from each individual and all expenditures of such money must be kept up to date and available for inspection by DMH staff
    2. The individual and/or his/her legal representative must be furnished ~~a~~ receipt, signed by the lawful agent(s) of the program, for all sums of money received and expended at least quarterly.

G. When planning and implementing services that offer individuals the opportunity for community participation, providers shall recognize that:

1. Individuals retain the right to assume informed risk. The assumption of risk is required to consider and balance the individual's ability to assume responsibility for that risk and a reasonable assurance of health and safety;
2. Individuals make choices during the course of the day about their everyday life, including daily routines and schedules; and,
3. Individuals have the opportunity to develop self-advocacy skills including but not limited to registering to vote.
4. Individuals must be afforded the same access to the community as people who do not have a mental illness, intellectual/ developmental disability or substance use disorder.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.3 Ethical Conduct

A. In addition to complying with ethical standards set forth by any relevant licensing or professional organizations, the governing authority and all staff members and volunteers (regardless of whether they hold a professional license) must adhere to the highest ethical and moral conduct in their interactions with the individuals and family members they serve, as well as in their use of program funds and grants.

B. Breaches of ethical or moral conduct toward individuals, their families, or other vulnerable persons, include but are not limited to, the following situations from which a provider is prohibited from engaging in:

1. Borrowing money or property
2. Accepting gifts of monetary value
3. Sexual (or other inappropriate) contact
4. Entering into business transactions or arrangements. An exception can be made by the Executive Director of the certified provider. The Executive Director of the certified provider is responsible for ensuring that there are no ethical concerns associated with the hiring and supervision practices.
5. Physical, mental or emotional abuse
6. Theft, embezzlement, fraud, or other actions involving deception or deceit, or the commission of acts constituting a violation of laws regarding vulnerable adults, violent crimes or moral turpitude, whether or not the employee or volunteer is criminally prosecuted and whether or not directed at individuals or the individuals' families
7. Exploitation
8. Failure to maintain proper professional and emotional boundaries
9. Aiding, encouraging or inciting the performance of illegal or immoral acts

10. Making reasonable treatment-related needs of the individual secondary or subservient to the needs of the employee or volunteer
11. Failure to report knowledge of unethical or immoral conduct or giving false statements during inquiries to such conduct
12. Action or inaction, which indicates a clear failure to act in an ethical, moral, legal, and professional manner
13. Breach of and/or misuse of confidential information.
14. Retaliation of any type towards an employee who reports, in good faith, a grievance, serious incident, concern with possible noncompliance with DMH Standards or DMH professional credentialing requirements.
15. Failure to report suspected or confirmed abuse or neglect of an individual receiving services in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.4 Limited English Proficiency Services and Cultural Competency

A. Language assistance services, including bilingual staff and interpreter services, must be offered at no cost to individuals with limited English proficiency. These services must be offered at all points of contact with the individual while he/she is receiving services. A detailed description of when and how these services will be provided must be clearly explained in the provider's policies and procedures.

B. All providers must develop and implement policies and procedures that address Culturally and Linguistically Appropriately Services (CLAS) federal guidelines developed by the Office of Minority Health (OMH), which is part of the US Department of Health and Human Services in order to improve access to care for Limited-English proficient individuals through the elimination of language and cultural barriers. All policies and procedures must include:

    1. The process for offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all services.
    2. How the agency informs individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
    3. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
    4. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the population in the service area.

C. Cultural competence describes the ability of an agency to provide services to individuals with diverse values, beliefs, and behaviors, including tailoring service delivery to meet the individual's social, cultural and linguistic needs. Policies and procedure manual must reflect the agency's efforts to integrate values, attitudes and beliefs of the individuals

served into the services provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.5 Local Grievance Policies and Procedures

A. There must be written policies and procedures for implementation of a process through which individuals' grievances can be reported and addressed at the local program/center level. These policies and procedures, minimally, must ensure the following:

   1. That individuals receiving services from the provider have access to a fair and impartial process for reporting and resolving grievances;
   2. That individuals are informed and provided a copy of the local procedure for filing a grievance with the provider and of the procedure and timelines for resolution of grievances;
   3. That individuals receiving services and/or parent(s)/legal representative(s) are informed of the procedures for reporting/filing a grievance with the DMH, including the availability of the toll free telephone number;
   4. That individuals receiving services and/or parent(s)legal representative(s) are informed of the procedures for reporting suspicions of abuse or neglect in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.
   5. That the program will post in a prominent public area the Office of Consumer Support (OCS) informational poster containing procedures for filing a grievance with DMH. The information provided by OCS must be posted at each site/service location.

B. The policies and procedures for resolution of grievances at the provider level, minimally, must include:

   1. Definition of grievances: a written or verbal statement made by an individual receiving services alleging a violation of rights or policy;
   2. Statement that grievances can be expressed without retribution;
   3. The opportunity to appeal to the executive officer of the provider agency, as well as the governing board of the provider agency;
   4. Timelines for resolution of grievances; and,
   5. The toll-free number for filing a grievance with the DMH Office of Consumer Support.

C. There must be written documentation in the record that each individual and/or parent guardian is informed of and given a copy of the procedures for reporting/filing a grievance described above, at intake and annually thereafter if he/she continues to receive services from the provider.

D. The policies and procedures must also include a statement that the DMH Certified Provider will comply with timelines issued by DMH Office of Consumer Support in resolving grievances initially filed with the DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.6 Use of Restraints

A. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support or if authorized as part of a behavior support plan for individuals with IDD. A mechanical restraint is the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

B. Providers are prohibited from the use of seclusion except for certified Crisis Stabilization Services. (See Rule 19.5.P–R) Seclusion means a behavior control technique involving locked isolation. Such term does not include a time-out.

C. Providers are prohibited from the use of chemical restraints. A chemical restraint is a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.

D. Providers must ensure that all direct service staff who utilize physical restraint/escort has successfully completed training and hold nationally recognized certification or DMH-approved training for managing aggressive or risk-to-self behavior (which includes verbal and physical de-escalation).

E. Providers must maintain a listing of all supervisory or senior staff members who have successfully completed required training and demonstrate competency in utilization of physical restraint.

F. Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum:

1. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:
   (a) A physical restraint is personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.
   (b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.
2. Requirements that physical restraint(s)/escort may be utilized only in emergency situations to protect the individual from injuring himself/herself or others. An

emergency is defined as a situation where the individual's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, or staff.

G. Requirements that physical restraints/escorts are used as specified in the Behavior Management Plan, ID/DD Waiver Behavior Support Plan/Crisis Intervention Plan only when all other less restrictive alternatives have been determined to be ineffective to protect the individual or others from harm. The utilization of other less restrictive alternatives must be documented in the individual's case record.

H. Providers must establish and implement policies and procedures that physical restraint is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of physical restraint. Additionally, individuals must not be restrained for more than fifteen (15) minutes at any one time. They must be released after those fifteen (15) minutes. A face-to-face assessment must take place while the individual is being restrained.

I. Providers must establish and implement policies and procedures specifying that physical restraint(s)/escort must be in accordance with a written modification to the comprehensive plan of the individual being served as well as all of the following:

1. Requirement(s) that physical restraint(s)/escort must be implemented in the least restrictive manner possible;
2. Requirement(s) that physical restraint(s)/escort must be in accordance with safe, approved restraining techniques based on techniques taught as part of certification in a behavior management technique; and;
3. Requirement(s) that physical restraint(s)/escort must be ended at the earliest possible time (i.e., when the individual's behavior has de-escalated and that individual is no longer in danger of harming him/herself or others);
4. Requirement(s) that physical restraint(s)/escort must not be used as a form of punishment, coercion or staff convenience;
5. Requirement(s) that supine and prone restraints are prohibited as part of an individual's Behavior Support Plan; and
6. Requirement(s) that all physical restraint(s)/escort can only be implemented by someone holding certification (see Rule 12.5.B.)

J. Requirements that physical restraint(s)/escort are being used in accordance with a Behavior Support Plan, ID/DD Waiver Behavior Support Plan/ Crisis Intervention Plan by order of a physician or other licensed independent practitioner as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider and documented in the case record.

K. Providers must establish and implement written policies and procedures regarding the use of physical restraint(s)/escort with implementation (as applicable) documented in the

Behavior Support Plan, ID/DD Waiver Behavior Support Plan/ Crisis Intervention Plan and in each individual case record:

1. Orders for the use of physical restraint(s)/escort must never be written as a standing order or on an as needed basis (that is, PRN).
2. A Behavior Support Plan must be developed by the individual's treatment team when these techniques are implemented more than three (3) times within a thirty (30) day period with the same individual. The Behavior Support Plan or ID/DD Waiver Behavior Support/Crisis Intervention Plan must address the behaviors warranting the continued utilization of physical restraint(s)/escort procedure in emergency situations. The Behavior Support Plan or ID/DD Waiver Behavior Support/Crisis Intervention Plan must be developed with the signature of the program's director who meets the qualification in Rule 11.3.
3. A supervisory or senior staff person with training and demonstrated competency in physical restraint(s) who is competent to conduct a face-to-face assessment will conduct such an assessment of the individual's mental and physical well-being as soon as possible but not later than within one (1) hour of initiation of the intervention. Procedures must also ensure that the supervisory or senior staff person trained monitors the situation for the duration of the intervention.
4. Requirements that staff records an account of the use of a physical restraint(s)/escort in a behavior management log that is maintained in the individual's case record by the end of the working day.
5. If you are unable to manage the individuals behavior, policies must be developed to address additional options staff are to take (ie. call mobile crisis team, 911, etc.).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 14.7 Time-Out</u>

A. Programs utilizing time-out must have written policies and procedures that govern the use of time-out and documentation of implementation of such procedures in case records of individuals receiving services. The use of time-out is prohibited for individuals with intellectual and development disabilities. The policy/procedures must include, at a minimum, the following provisions:

   1. Clear definition(s) of time-out and the appropriate conditions and documentation associated with its use:
      (a) A time-out is a behavior management technique which removes an individual from social reinforcement into a non-locked room, for the purpose of calming. The time-out procedure must be part of an approved treatment program. Time-out is not seclusion.
      (b) Quiet time is a behavior management technique that is part of an approved treatment program and may involve the separation of the individual from the group, for the purpose of calming. Quiet time is not time-out.

2. Requirement(s) ensuring that the use of time-out procedures is justified as documented and approved in an individual plan.
3. Requirement(s) ensuring that time-out is used only after less restrictive procedures have been implemented and determined to be ineffective. The utilization of other less restrictive alternatives must be documented in the individual case record.
4. Requirement(s) that a locked door must not be component of timeout.

B. Programs utilizing time-out must have written and implemented policies and procedures that time-out is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of time-out. Placement of an individual in a time-out room cannot exceed one (1) hour. ID/DD Waiver Services of any type are prohibited from the use of time-out.

C. There must be written and implemented policies and procedures requiring that a Behavior Management Plan be developed by the individual's treatment/support team, including participation of the individual as appropriate, to address the behavior(s) warranting the utilization of the time-out procedure and adhere to the following:

1. The Behavior Management Plan must be developed in accordance with the individual's plan and have signature approval by the program's director who meets the qualification in Rule 11.3.
2. The Behavior Management Plan must not include the use of time-out as a form of punishment, coercion or for staff convenience.

D. The utilization of time-out must be documented in a behavior log completed/maintained in the individual's case record.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 14.8 Search and Seizure</u>

A. Agencies must develop policies and procedures regarding the search of the individual's room, person and/or possessions (Exception: Unannounced searches may not be conducted in Supported Living, Shared Supported Living and Host Home settings unless there is reason to believe that a crime has been committed), to include but not limited to;

1. Circumstances in which a search may occur;
2. Staff designated to authorize searches;
3. Documentation of searches; and
4. Consequences of discovery of prohibited items.

B. Policy regarding screening for prohibited/illegal substances (Exception: Staff may not screen for prohibited/illegal substances in Supported Living, Shared Supported Living and Host Home settings unless there is reason to believe that a crime has been

committed; in which case, law enforcement should be contacted immediately), to include but not limited to:

1. Circumstances in which screens may occur;
2. Staff designated to authorize screening;
3. Documentation of screening;
4. Consequences of positive screening of prohibited substances;
5. Consequences of refusing to submit to a screening; and
6. Process for individuals to confidentially report the use of prohibited substances prior to being screened.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 15: Serious Incidents

Rule 15.1 Serious Incidents to Report to DMH Within Twenty-Four (24) Hours of Incident

A. The following are examples (not an exhaustive list) of types of serious incidents that must be reported to the DMH, Office of Incident Management and other appropriate authorities within twenty-four (24) hours or the next working day, as specified below:

1. Suicide attempts on provider property at a provider-sponsored event, or by an individual being served through a community living program;
2. Unexplained or unanticipated absence of an individual receiving services of any length of time from any DMH certified program of any type;
3. Incidents involving injury of an individual receiving services while on provider property, at a provider-sponsored event, or being transported by a DMH Certified Provider;
4. Emergency hospitalization or emergency room treatment of an individual receiving services;
5. Accidents which require hospitalization that may be related to abuse or neglect, or in which the cause is unknown or unusual;
6. Disasters, such as fires, floods, tornadoes, hurricanes, blizzards, etc.;
7. Any type of mandatory evacuation by local authorities that affects the program/facility or site; and,
8. Use of seclusion or restraint that was not part of an individual's treatment Behavior Management Plan, or ID/DD Waiver Behavior Support/Crisis Intervention Plan that was planned but not implemented properly, or resulted in discomfort or injury for the individual.

B. Serious incidents must be reported in writing to DMH, Office of Incident Management within twenty-four (24) hours of the incident. Additional information may be requested based on the circumstances. The written report must address initial information known about the incident to include, but not limited to:

1. Name of Provider
2. Date;
3. Time;
4. Physical location;
5. Who was involved;
6. What led to the incident;
7. A description of the incident;
8. Consequences of incident;
9. Witnesses; and,
10. Notifications.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 15.2 Serious Incidents to Report to DMH Within Eight (8) Hours of Discovery or Notification of Incident

A. Serious incidents that must be reported to the DMH Office of Incident Management within eight (8) hours of discovery or notification of the incident include:

   1. Death of an individual on provider property, participating in a provider-sponsored event, being served through a certified community living program, Crisis Stabilization Unit, Primary Residential Treatment , Transitional Residential Treatment, and/or being served through the ID/DD Waiver,
   2. Unexplained absences from any of the previously mentioned programs or Alzheimer's Day Services programs.
   3. Suspicions of abuse or neglect of an individual receiving services while on provider property, at a provider-sponsored event, or being transported by a DMH Certified Provider.

B. The above listed incidents must be reported verbally to the Office of Incident Management within eight (8) hours to be followed by the written Serious Incident Report within twenty-four (24) hours as outlined in Rule 15.1.B.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 15.3 Policies and Procedures for Serious Incidents

The provider must have written and implemented policies and procedures in place regarding serious incidents that include:

A. What constitutes a serious incident;

B. Prevention of serious incidents;

C. Remedial actions;

D. Reporting of serious incidents;

E. Documentation of serious incidents;

F. Training and documentation that staff have received, and acknowledged, information on required reporting of abuse, neglect and/or exploitation of a vulnerable person;

G. Maintenance of documentation related to serious incidents;

H. Assurance of cooperation with DMH for follow up to serious incidents;

I. Analysis of all serious incidents; and,

J. Staff responsible for analysis of serious incidents.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 15.4 Written Analyses of All Serious Incidents

A. The governing authority or a committee designated by the governing authority (which can include the Quality Management Committee required in Chapter 9) must review all serious incidents and conduct a written analysis of all serious incidents at least quarterly. Written analysis must be made available to DMH for review upon request.

B. If a committee is designated by the governing authority, that committee must include representatives of multiple disciplines and positions within the agency. For example, medical staff, administrative staff, human resources, clinical staff, etc.

C. The written analysis must address the following:

1. A determination of the cause of each incident;
2. Identification of any trends in serious incidents; and,
3. Remedial actions to be taken to prevent similar future events.

D. Remedial actions must be communicated to staff affected by the required actions.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 16: Service Organization

Rule 16.1 Determinations of Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), and/or Intellectual/Developmental Disability (IDD)

A. All of the following information must be documented to support a determination of serious emotional disturbance:

1. Youth has at least one (1) of the eligible diagnosable mental disorders defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
2. Youth with serious emotional disturbance are birth up to twenty-one (21) years.
3. The identified disorder must have resulted in functional impairment in basic living skills, instrumental living skills, or social skills, as indicated by an assessment instrument/approach approved by the DMH.

B. All of the following information must be documented to support a determination of serious mental illness:

1. An individual who meets the criteria for one of the eligible diagnostic categories defined in the most current version of the DSM.
2. Adults with serious mental illness are age eighteen (18) and over.
3. The identified disorder must have resulted in functional impairment in basic living skills, instrumental skills or social skills, as indicated by an assessment instrument/approach approved by the DMH.

C. All of the following must be documented to support admission to IDD programs:

1. ID/DD Waiver Services:
   (a) The person meets the criteria for the level of care found in an intermediate care facility for individuals with intellectual disabilities (ICF/IID), as determined by the Diagnostic and Evaluation Team at one of the state's five (5) comprehensive IDD Regional Programs and
   (b) Is eligible for Medicaid through one (1) of the categories specified in the federally approved ID/DD Waiver application; or
2. Other IDD Services: Meets the requirements for a Certificate of Developmental Disability as defined in the Developmental Disabilities Assistance Act.
3. IDD Community Support Program (CSP):
   (a) Meets the Needs-Based Criteria established in the 1915(i) Medicaid State Plan Amendment and
   (b) Meets the criteria for a Certificate of Developmental Disability.
   (c) Medicaid eligibility

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.2 Admissions to Services

A. The provider must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that:

   1. Provide a phone number where contact can be made to arrange for an appointment;
   2. Assure the person requesting services only has to make one call to arrange an appointment.

B. Written policies and procedures must address admission to services and must at a minimum:

   1. Describe the process for admission and readmission to service(s).
   2. Define the criteria for admission or readmission to service(s), including:
      (a) Description of the population to be served (age(s), eligibility criteria, any special populations, etc.)
      (b) Process for determination of appropriateness of services to address the needs of the individual seeking services
      (c) Number of residents to be served (providers of community living services only)
      (d) Expected results/outcomes
      (e) Methodology for evaluating expected results/outcomes.
   3. Assure equal access to treatment and services and non-discrimination based on ability to pay, race, sex, age, creed, national origin, or disability for individuals who meet eligibility criteria.
      (a) For the ID/DD Waiver, a provider chosen by an individual cannot refuse to admit him/her solely on the basis of the his/her support needs, if an appropriate placement is available.
      (b) If an individual is denied admission, the provider must submit written justification for the denial to the individual's Support Coordinator to be maintained in the record;
      (c) Additional referrals may not be made by Support Coordination to providers who deny admission to someone who has chosen them for a period of one (1) month, or greater, depending on a provider's pattern of behavior of denying admission based on an individual's needed level of support.
   4. Describe the process or requirements for intake/initial assessment, including the process for requesting appropriate consent to obtain relevant records from other providers.
   5. Describe the procedure for individuals who are ordered to treatment by the court system.
   6. Describe written materials provided to individuals upon admission, including materials that may be included in an orientation packet, etc.
   7. Describe~~s~~ the process for informing individuals, youth (if age appropriate) and youth's parent(s)/legal representative(s) of their rights and responsibilities (including any applicable program rules) prior to or at the time of admission.

8. Describe the process to be followed when admission or readmission to service(s) offered by the provider is not appropriate for the individual, including referral to other agencies and follow-up, as appropriate. Such referral(s) and follow-up contacts must be documented.
9. Describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available by the provider.
10. Assure equal access to treatment and services for HIV-positive persons who are otherwise eligible
11. Describe procedures for providing a schedule to individuals and their families for each service and/or program that includes the hours of daily operation, number of days per year the service/program is available, and the scheduled dates of closure/unavailability and reasons.
12. Describe procedures for disbursing funds on behalf of individuals receiving services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.3 Discharge and Termination

A. Discharge and termination are two unique terms and actions.

B. Termination is the action utilized and documented to discontinue a service and/or program within a DMH Certified Provider agency.

C. Discharge is the action utilized and documented to signify that an individual is no longer receiving services through that particular DMH Certified Provider agency.

D. All providers must implement policies and procedures for discharge or termination from the service/program which must, at a minimum, address the following:

   1. Reason(s) for discharge\termination.
   2. Assessment of progress toward objectives contained in the individual plan
   3. Discharge instructions given to the individual who received services or their authorized representative, parent(s)/legal representative(s), including referrals made
   4. Any other information deemed appropriate to address the needs of the individual being discharged from the program.

E. In addition to Rule 16.3 D, all providers of community living services to children/youth in the custody of the MS Department of Human Services must adhere to the following regarding discharge:

   1. The DHS social worker from the county of residence of the child/youth is provided the opportunity to be in involved in the discharge/placement plans if the child is in the custody of DHS.

2. Children and youth in the custody of the MS Department of Human Services are provided an opportunity for one pre-placement visit by their DHS Social Worker prior to discharge.
3. Documentation that an appointment has been scheduled with the CMHC responsible for services in the county where the child/youth will reside upon discharge.

F. Individuals living in community settings cannot be discharged or terminated from the service in a manner that is not in full compliance with the terms of the signed lease/rental/ residential fee agreement. In addition, the community living service provider must ensure that alternative living arrangements are made that are appropriate for the individual. Those arrangements should be designed to mitigate the likelihood that the individual will be homeless as a result of being discharged or terminated from the community living program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.4 Program Postings

A. Program rules (if applicable) for any service and/or program must be posted in a location highly visible to the individuals served and/or made readily available to those individuals. (Exception: Supervised Living, Shared Supported Living, Supported Living and Host Homes.)

B. All Programs must post emergency contact number(s) in a conspicuous location. Program postings in community living settings should not conflict with the efforts to provide a home-like environment for the individuals living in the setting.

C. For day programs of all types, community living programs of all types, and Crisis Stabilization Units, the following contact information should be kept securely at the program/service location and available to all staff:

1. Family member(s) or other contacts (if appropriate and consent is on file)
2. Community support specialist, Targeted Case Manager, Community Support Specialist, therapist, and/or Support Coordinator for individuals (if applicable).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.5 Service and Program Design

A. Activities must be designed to address objectives/outcomes in the individual plan directing treatment/support for the person. At a minimum, individual plan objectives/outcomes must reflect individual strengths, needs, preferences and behavioral issues of individuals and/or families/guardians (as appropriate) served by the program or through the service as reflected by intake/assessments and/or progress notes.

B. Services and programs must be designed to provide a Person-Centered Recovery Oriented system of services with a framework of recovery supports that are self-directed, individualized, culturally responsive, trauma informed, and that provide for community participation opportunities. Services should be measurable and individualized for each individual receiving services

C. Services and programs must be designed to promote and allow independent decision making by the individual and encourage independent living, without compromising the health and safety of the individuals being served.

D. Providers must present information in a manner understandable to the individual so that he/she can make informed choices regarding service delivery and design, available providers and activities which comprise a meaningful day for him/her.

E. Programs must provide each individual with activities and experiences to develop the skills they need to support a successful transition to a more integrated setting, level of service, or level of care.

F. The services provided as specified in the individual plan must be based on the requirements of the individual rather than on the availability of services/staff.

G. All efforts must be implemented to design a service environment that is safe and conducive to positive learning and life experiences. Persons served in the program whose behaviors are significantly disruptive to others in the same environment must be afforded the opportunity and assistance to change those behaviors through a systematic support plan. Persons receiving services may not be discharged from a service or program due to disruptive behaviors unless they pose a risk for harm to other people receiving the service. Efforts to keep an individual enrolled in the service or program must be included in the plan and documented in the record.

H. Persons enrolled in ID/DD Waiver services must also collaborate with the Support Coordinator to determine a need for Behavior Support Services before a decision is finalized to discharge a person from the service.

I. If mental health services are provided in a school setting, the provider must maintain a current written interagency agreement(s) (including a confidentiality statement), signed by the Executive Officer of the mental health provider agency and the superintendent of the school district, that at a minimum:

1. Describes in detail the respective responsibility(ies) of each entity in the provision of mental health services provided in the local school and any support services necessary for the provision of that service (such as facilities, staffing, transportation, etc.).
2. Includes a written acknowledgment of the school district’s receipt and understanding of standards applicable to the children’s mental health services.

J. Within twenty-four (24) hours prior to the release or discharge of any civilly committed individual from community mental health services, other than a temporary pass or because of absence due to sickness or death in the patient's family, the program director or executive director must give or cause to be given notice of such release or discharge to one (1) member of the individual's immediate family, provided the individual, eighteen (18) years or older, has signed an appropriate consent to release such discharge information and has provided in writing a current address and telephone number, if applicable, to the director for such purpose.

K. Services and plan development must reflect cultural considerations of the individual and be conducted by providing information in a plain language and in a manner that is accessible to the individuals and persons who have limited English proficiency.

L. For IDD Waiver Services, required staff must participate in the development of each person's plan of services and supports.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.6 Staffing

A. All services and programs must provide the level of staffing needed to ensure the health, safety, and welfare of the individuals served, and provide essential administrative and service functions.

B. Only a licensed health care professional can provide nursing care, medical services, or medication, in accordance with the criteria, standards, and practices set forth by their respective licensing entity.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.7 Confidentiality

A. Personnel must maintain the confidentiality rights of individuals they serve at all times across situations and locations, such as in waiting areas to which the public has access, while speaking on the telephone or, in conversing with colleagues.

B. The provider must have written policies and procedures and related documentation pertaining to the compilation, storage, and dissemination of individual case records that assure an individual's right to privacy and maintains the confidentiality of individuals' records and information.

C. Compilation, storage and dissemination of individual case records, including related documentation, must be in accordance with these policies and procedures, which at a minimum must include:

1. Designated person(s) to distribute records to staff;
2. Specific procedures to assure that records are secure in all locations;
3. Procedures to limit access to records to only those who have been determined to have specific need for the record, including written documentation listing those persons;
4. Procedures for release of information that are in accordance with all applicable state and federal laws. Generally, this means case records and information shall not be released except upon prior written authorization of the individual receiving services or his/her legally authorized representative; upon order of a court of competent jurisdiction; upon request by medical personnel in a medical emergency or when necessary for the continued treatment or continued benefits of the individual. These procedures at a minimum must:
   (a) Describe the process for releasing information about individuals receiving services only upon written consent, including the identification of the staff responsible for processing inquiries or requests for information regarding individuals receiving services.
   (b) Describe the process for releasing information about an individual receiving without prior written consent, that is, in cases of a medical emergency or upon receipt of a court order.
   (c) Provide that written consent to release information is not combined with any other consents or releases by the individual receiving services.
5. Procedures prohibiting the disclosure that a person answering to a particular description, name, or other identification has or has not been attending the program without prior written consent of the person specifically authorizing such disclosure;
6. Procedures prohibiting re-disclosure of information obtained by the program and released by the program without specific prior written consent of the person to whom it pertains;
7. Procedures requiring written consent of the individual receiving services or their guardian, when appropriate, prior to disclosing identifying information to third-party payer; and,
8. Procedures addressing the release of information regarding individuals receiving alcohol and other drug disorders services, in accordance with applicable federal regulations.

D. Records containing any information pertaining to individuals receiving services must be kept in a secure room or in a locked file cabinet or other similar container when not in use;

E. All paper case records must be marked "confidential" or bear a similar cautionary statement; all electronic health records or digital filing must be privacy protected and contain a statement of confidentiality or similar cautionary statement; and

F. No program shall release records of individuals receiving services for review to a state or federal reviewer other than DMH staff without a written statement indicating:

1. The purpose of the review;
2. Staff to conduct the review;
3. That reviewer(s) are bound by applicable regulations regarding confidentiality and all others that apply; and,
4. Reviewer(s) signature(s) and the date signed.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.8 Case Record Management

A. A single case record must be maintained for each individual receiving services (exception: A/D Prevention Services, Consultation and Education Services and Family Support and Education Services) from the provider agency. In lieu of access to case records staff must utilize an on-site working record that contains information from the case record that is utilized to provide services at that location (e.g., individual plans, emergency contact information, and medication profile).

B. The provider must maintain an indexing or referencing system that allows for locating particular individual case records whenever they are removed from the central file area.

C. Records of individuals served must be readily accessible to authorized staff and there must be written procedures assuring accessibility to records by emergency staff after hours.

D. All entries in individuals' records must be in a permanent form (i.e. ink), accurate, legible, dated, signed, and include the credentials of staff making the entry. Corrections in the original information entered in the record(s) of individuals served by the program must be made by marking a single line through the changed information. Changes must be initialed and dated by the individual making the change. The correct information should be entered in the next available space. Correction fluid, erasing, or totally marking out original information is not permissible.

E. Late entries to the record should be avoided. However, late entries must also be documented. Late entries should be documented as soon as possible. Late entries should be identified as a "late entry". The date and time when the entry is actually being made must be included. Events described in the late entry must include the actual date and time (if available) that the event(s) occurred.

F. No information in an individual's record shall contain the whole name or other identifiable information of another individual receiving service.

G. For alcohol and other drug disorders services records, the case must be closed when no contacts are recorded for ninety (90) days.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.9 Assessment

A. Adults with a serious mental illness (SMI) and children and youth with serious emotional disturbance (SED) must be seen in person or by telemedicine and evaluated by a licensed physician, licensed psychologist, psychiatric/mental health nurse practitioner, physician assistant, licensed professional counselor (LPC) , licensed marriage and family therapist (LMFT), or Licensed Certified (clinical) Social Worker (LCSW) to certify that the services planned are medically/therapeutically necessary for the treatment of the individual. These professionals must see the individual in person or by telemedicine annually (or more often if medically indicated) to certify the same in the record.

B. Certification and recertification must be documented as part of the individual plan directing treatment/support.

C. For all individuals receiving mental health services and/or substance use disorders services, the initial biopsychosocial assessment and subsequent biopsychosocial assessments are the face-to-face securing of information from the individual receiving services and/or collateral contact, of the individual's family background, educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the individual and/or family.

D. The initial biopsychosocial assessment and subsequent biopsychosocial assessments must be completed by a DMH Credentialed Mental Health Therapist, DMH Credentialed IDD Therapist, DMH Credentialed Addictions Therapist or professionally licensed individual.

E. The following priority groups of individuals with serious mental illness, children/youth with serious emotional disturbance and individuals with an intellectual/developmental disability must receive an Initial Assessment within fourteen (14) days of the date that services are sought and/or the date the referral is made.

   1. Individuals discharged from an inpatient psychiatric facility
   2. Individuals discharged from an institution
   3. Individuals discharged or transferred from Crisis Stabilization Services
   4. Individuals referred from Crisis Response Services.

F. For individuals in need of Psychiatric/Physician Services, an appointment for those services must be made and documented during the initial biopsychosocial assessment.

G. For adults receiving Outpatient Mental Health Services, a DMH approved functional assessment must be conducted within thirty (30) days of Initial Assessment and at least every twelve (12) months thereafter.

H. For children and youth receiving mental health services, a DMH approved functional assessment must be conducted within (30) days of Initial Assessment and at least every six (6) months thereafter.

   1. If a child/youth has been evaluated by the school district or other approved examiner to determine the need/eligibility for special education services, the mental health service provider must document their request and/or receipt of such evaluation results, provided that appropriate written consent was obtained from the parents/legal representative to do so. Copies of the request(s) for the release of information and any special education evaluation results received must be maintained in the case record.

I. For individuals with IDD who have been evaluated by one (1) of the five (5) Diagnostic and Evaluation Teams, or by another licensed examiner to determine the need for/eligibility for ICF/ IID level of care, special education, the IDD Community Support Program and/or a Certificate of Developmental Disability, the evaluation(s) must be maintained in each individual's record as part of the initial assessment process.

J. For children ages thirty-six (36) months and younger, the assessment requirements for First Steps Early Intervention Programs are applicable.

K. For children participating in DMH Child Development Programs, a functional skills assessment must be administered annually. The provider may select the functional skills assessment with approval from the BIDD.

L. For individuals receiving substance use disorders services, a DMH approved functional assessment must be conducted within timelines according to the service(s) received.

M. For Alcohol and Other Drug Disorders Services, all individuals receiving substance abuse treatment services must receive the TB and HIV/AIDS Risk Assessment at the time of the Intake/Initial Assessment except under the following circumstances:

   1. For Transitional Residential Services - The Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying the assessment(s) was administered, with documentation of follow-up of results if applicable, in a primary treatment program completed within the last thirty (30) days.
   2. For Recovery Support Services - The Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that both risk assessment(s) were administered with documentation of follow-up and results, if applicable, during substance abuse treatment program completed within the last thirty (30) days.

N. In addition to the Initial Assessment, a DUI Diagnostic Assessment for individuals in the DUI program for second and subsequent offenders must contain the following information:

1. A motor vehicle report (or evidence of a written request) which is obtained by the service provider from the Department of Public Safety. This record must contain: Previous DUI's and Moving violations.
2. The results and interpretations of the SASSI or other DMH approved diagnostic instrument. The approval must be obtained in writing.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 17: Individual Planning of Treatment, Services and Supports

Rule 17.1 Individual Plans

A. The individual plan is the overall plan that directs the treatment\support of the individual receiving services. The individual plan should be designed to increase or support independence and community participation. The individual plan may be referred to as the Treatment Plan, Plan of Services and Supports, Individual Service Plan, Wraparound Plan or Person-Centered Plan. The name of the plan is dependent upon the population being served and the process utilized to develop the plan.

B. The plan must be based on the strengths, challenges, desired outcomes, and activities to support outcomes of the individual receiving services and his/her family/legal representative (if applicable). Outcomes should be identified by the individual, family/legal representative (if applicable), and treatment/support team.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 17.2 Development of Individual Plans

A. Providers must utilize planning approaches that are considered to be best practices or evidence-based by their respective areas of focus (i.e. working with adults with SMI, children/youth with SED, individuals with co-occurring disorders, individuals with substance use disorders and individuals with intellectual/developmental disabilities, the elderly, etc.). Planning approaches must be documented and implemented through the development of policies and procedures specific to this process and the population being served.

B. Planning approaches must address the following, at a minimum:

    1. The development of an individualized treatment/support team that includes the individual, service providers and other supports (as appropriate) that may be identified and utilized by the individual or team members;
    2. A focus on recovery/resiliency and/or person centeredness, depending on the population;
    3. A focus on individual strengths and how to build upon strengths to achieve positive outcomes; and,
    4. Proactive crisis planning, depending on the individual receiving services.

C. The Plan of Services and Supports for individuals with IDD:

1. The individual will lead the person centered planning process where possible. The individual's representative/legal guardian should have a participatory role, as needed and as defined by the individual. The meeting:
   (a) Includes people chose by the individual.
   (b) Provides necessary information and support to ensure the individual directs the process to the maximum extent possible, and is enable to make informed choices and decisions.
   (c) Is timely and occurs at times and places convenient to the individual.
   (d) Reflects the cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to the individuals with disabilities and person who are limited English proficient.
   (e) Includes strategies for resolving conflict or disagreement within the process including clear conflict-of-interest guidelines for all planning participants.
   (f) Offers informed choices to the individual regarding the services and supports they received and from whom.
   (g) Includes a method for the individual to request updates to the plan as needed.
   (h) Records the alternative home and community based settings that were considered by the individual.
2. The Plan of Services and Supports must:
   (a) Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need as well as what is important to him/her with regard to preferences for the delivery of such services and supports.
   (b) Reflect that the setting in which the individual resides is chosen by the individual. The setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access an individual not receiving ID/DD Waiver services.
   (c) Reflect the individual's strengths and preferences.
   (d) Reflect clinical and support needs as identified through the functional assessment.
   (e) Include individually identified outcomes for services.
   (f) Reflect the services and supports (paid and unpaid) that will assist the individual to achieved identified goals and the providers of those services and supports, including natural supports.
   (g) Reflect risk factors and measures in place to minimize them, including individuals back-up plans and strategies when needed.
   (h) Be understandable to the individual receiving services and supports, and the individuals important in supporting him/her. At a minimum, for the PSS to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English language proficiency.
   (i) Identify the individual and/or entity responsible for monitoring the PSS.
   (j) Be finalized and agreed to, with the informed consent of the individual in writing, and be signed by all individuals and providers responsible for its implementation.
   (k) Be distributed to the individual and others involved in implementing the PSS.

(l) Must prevent the provision of unnecessary or inappropriate services and supports.

(m) Must Document that any modifications made to a person's ability to access the community or make choices about his/her daily life:

  (1) Identify a specific and individualized assessed need.
  (2) Have documentation of the positive behavior interventions and supports used prior to any modification of the person centeredness of the PSS.
  (3) Have documentation that less intrusive methods have been tried and did not work.
  (4) Include a clear description of the condition that is directly proportionate to the specific assessed need.
  (5) Include regular collection and review of data to measure the ongoing effectives of the modification.
  (6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
  (7) Include the informed consent of the individual.
  (8) Include an assurance that interventions and supports will cause no harm to the individual.

(n) Reviewed and revised upon reassessment of the functional need, at least annually, when the individual circumstances or needs change significantly, or at the request of the individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 18: Targeted Case Management Services

Rule 18.1 Targeted Case Management Activities

A. Targeted Case Management Services are defined as services that provide information/referral and resource coordination for individuals and/or his/her family, or other supports. Targeted Case Management Services are directed towards helping the individual maintain his/her highest possible level of independence. Case managers monitor the individual service plan and ensure team members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the person's team may need to review the service plan for updates if the established plan is not working.

B. Targeted case management may be provided face-to-face or via telephone. Targeted case management is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than a community mental health center or IDD Regional Program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 18.2 Provision of Mental Health Targeted Case Management Services

A. Targeted Case Management must be included in the individual's plan.

B. The frequency of Targeted Case Management services will be determined by the complexity of the situation and the need of the individual receiving services, but shall not occur less than once monthly.

C. The staff caseload for Mental Health Targeted Case Management Services must not exceed one hundred (100) individuals. Caseload sizes must be based on the complexity of the needs of the person and whether or not the staff member has additional responsibilities.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 18.3 Provision of IDD Targeted Case Management Services

A. IDD Targeted Case Management is provided by one (1) of the State's five (5) IDD Regional Programs.

B. IDD Targeted Case Managers are responsible for the following:

1. Development of the Plan of Services and Supports
2. Coordination and monitoring of services to include the following:

(a) Services are adequate, appropriate and meet the person's unique needs.
(b) Follow-up activities and contact that are necessary to ensure the PSS is effectively implemented and adequately addresses the person's support needs.
(c) Ensuring the changing needs of the individual are addressed on an ongoing basis.
(d) Providing resource information and referral to link individuals with medical, social, employment, educational or other providers and programs and services to meet the person's needs and achieve the outcomes identified in the PSS.
(e) Reassessing an individual at least annually for eligibility to ensure he/she continues to meet the needs-based criteria.

C. Contacts include face-to-face or phone contacts with the person, family or legal representative(s), service providers or other entities. At least monthly, the IDD Targeted Case Manager must contact the individual receiving services and his/her legal representative to assess satisfaction with services and to address any changing needs. The IDD Targeted Case Manager must have face-to-face contact with the individual at every other month in the service setting. If a person is not receiving other services, the Targeted Case Manager must see him/her face-to-face at least quarterly.

D. The caseload for IDD Targeted Case Management is thirty-five (35).

E. IDD Targeted Case Managers must adhere to the requirements and guidelines in the IDD Targeted Case Management Manual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 19: Crisis Services

Rule 19.1 Crisis Response Services

A. Crisis Response is an intensive therapeutic service which allows for the assessment of and intervention in a mental health crisis. Crisis Response Services are provided to children and adults who are experiencing a significant emotional/behavioral crisis in which the individual's mental health and/or behavioral health needs exceed the individual's resources (in the opinion of the mental health professional assessing the situation.) Trained Crisis Response staff provides crisis stabilization directed toward preventing hospitalization. Staff must be able to triage and make appropriate clinical decisions, including assessing the need for inpatient services or less restrictive alternatives. Crisis Response Services will deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. Without Crisis Response intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility. (Crisis Response Services do not include the Crisis Intervention/Crisis Support Services provided through the ID/DD Waiver.)

B. Crisis Response Services must be made available to the general public in every county/area served by providers certified by DMH to provide Crisis Response Services.

C. Crisis Response Services must be available 24 hours a day, 7 days a week, and 365 days a year. Crisis Response Services must have the capability to respond to multiple crisis calls at a time. Services include:

    1. A single toll-free telephone number which covers the provider's entire catchment area for crisis calls.
    2. Mobile Crisis Response capability for the provider's entire catchment area.
    3. "Walk-in" Crisis Response capability at all DMH certified service locations in the provider's catchment area.

D. The "on-call" Crisis Response staff answering the toll-free telephone number must:

    1. Ensure that a mental health representative is available to speak with an individual in crisis and/or family members/legal representatives of the individual at all times.
    2. Have the ability to triage and determine the need to deploy Mobile Crisis Response Services.
    3. Ensure individuals or family members/legal representatives of the individual in crisis should only have to call a single time to the toll-free number to request and receive assistance.

E. Crisis Response Services must coordinate with the DMH Office of Consumer Support (OCS) and respond to crisis call referrals from the OCS generated from the DMH Help Line (1-877-210-8513) or any agency DMH contracts with to provide after-hours Help Line coverage.

F. The provider must:

1. Ensure Crisis Response Services availability is publicized, including a listing in the telephone directories for each county served by the provider and on the homepage of the provider's website.
2. Ensure the individual speaks with a trained professional if an answering service is used after typical work hours (which are permissible.) Automated answering devices are not permissible.
3. Ensure the provider's toll-free number is provided to DMH, Office of Consumer Support (1-877-210-8513.)

G. Mobile Crisis Response Services with a mental health professional(s) must:

1. Be able to respond within one (1) hour of initial time of contact if in an urban setting and within two (2) hours of initial time of contact if in a rural setting.
2. Designate a strategic, publicized location where the person in crisis can meet with a mental health professional. The staff person is not required to see the individual in the individual's home, but this is permissible and recommended.
3. Complete an assessment of the individual's risk and acuity using an assessment tool as required by DMH. The assessment will include, but not be limited to, current risk level related to suicide/homicide, substance abuse, mental status, current and past mental health diagnoses and treatment, coping skills and medical condition.
4. Utilize a team approach to Mobile Crisis Response if warranted to adequately address the crisis situation. Law enforcement should accompany the Mobile Crisis Response Team if safety is a concern.
5. Work to immediately stabilize the individual's crisis situation using solution- focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration or placement in a more segregated setting.
6. Assess current natural supports and make a determination if the individual can safely remain in the community.
7. Transport or arrange transportation to the most appropriate treatment setting if the individual is determined to be a danger to self or others.
8. Provide for the level of service the individual requires, mitigate the crisis situation and if known, support his/her long term recovery goals (ex., Crisis Support Plan, Advanced Directive.)

H. Policies and procedures must be in place which detail how "walk-in" crisis situations will be handled by Crisis Response Services. The policies and procedures must be specific to each DMH certified location in the provider's catchment area.

I. Crisis Response Services must have access to medical and psychiatric support as needed (24/7/365 days a year). Medical and psychiatric support can be provided through the use of telemedicine (i.e., computer tablet, laptop, etc.)

J. Crisis Response Services must facilitate and verify formal initial assessment and therapy appointments, when the crisis situation subsides, with the mental health provider of the individual's choice (if the individual is able to remain in the community) utilizing the "warm handoff" method. A "warm handoff" is an approach to care transitions in which health care providers directly link individuals with typical service providers, using face-to-face or phone transfer. "Warm handoff" achieves very high rates of treatment enrollment for this vulnerable group.

K. Follow-up daily and provide any necessary services to the individual between the initial stabilization of the crisis and the initiation of typical therapeutic and psychiatric care.

L. Recipients of Crisis Response Services do not have to be currently or previously enrolled in any of the services provided by the provider. Crisis Response Services may be provided to an individual before he/she participates in the initial assessment that is part of the intake/admission process.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

19.2 Crisis Response Services Staffing Requirements

A. Crisis Response Services must consist, at a minimum, of the following staff:
   1. A Certified Peer Support Specialist(s),
   2. A Licensed and/or Credentialed Master's Level Therapist(s) with experience and training in crisis response (Provisionally Licensed and/or Credentialed Therapists are excluded),
   3. A Community Support Specialist(s) with experience and training in crisis response,
   4. A Crisis Response Coordinator for the provider's catchment area. Coordinator must be a Licensed and/or Credentialed Master's Level Therapist with a minimum of two years' experience and training in crisis response.
   5. At least one staff member must have experience and training in crisis response to each population services by the provider (MH, IDD, and/or SUD).

B. There must be documentation that all staff assigned to Crisis Response Services are trained in the policies and procedures required for Pre-Evaluation Screening and Civil Commitment Examinations. Master's level staff must be certified to complete the Pre-Evaluation Screening for Civil Commitment.

C. All staff members providing Crisis Response Services must obtain and maintain certification in a professionally recognized method of crisis intervention and de-escalation (ex. CPI, the Mandt system or Nonviolent Crisis Intervention.).

D. All staff members providing Crisis Response Services must obtain nationally recognized training for specialized mental health crisis response/intervention training (i.e. Mental Health First Aid.)

E. All staff members providing Crisis Response Services must obtain nationally recognized training for suicide prevention (i.e., Applied Suicide Intervention Skills Training.)

F. Crisis Response Services will provide training to all clinical co-workers regarding the development and implementation of Crisis Support Plans.

G. Crisis Response Coordinator must request to be a member of all adult and children's Multi-Disciplinary Assessment and Planning (Making A Plan) (MAP) Teams in the provider's catchment area and attend meetings regularly. If there is no local adult or children's MAP Team, the Crisis Coordinator is required to initiate the development of MAP Teams within their catchment area.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

19.3 Crisis Response Service Coordination

A. Crisis Response Services must provide crisis assessment and crisis support when requested by entities providing services to the following:

   1. Individuals held in a Certified Mental Health Holding Facility who are waiting for bed availability after an inpatient commitment.
   2. Individuals held in a local jail with a mental health emergency.
   3. Individuals presenting in local emergency rooms with a mental health emergency.

B. Crisis Response Services must offer to all licensed hospitals with emergency departments in the catchment area:

   1. Training of emergency room staff in handling mental health emergencies.
   2. Consultation in the care of individuals who are admitted to the hospital for medical treatment of suicide attempts or other mental health emergencies.

C. Crisis Response Services must provide assessment and arrange transportation twenty-four (24) hours a day, seven (7) days a week to the DMH-certified Crisis Residential Services (Crisis Stabilization Unit) designated for the provider catchment area for individuals in need of Crisis Residential Services.

D. Crisis Response Services must attempt to develop a close working relationship with law enforcement (i.e. city police, county sheriff, campus police, county jails, youth detention centers, etc.) in the provider's catchment area and request appointment of officers to the provider's Mobile Crisis Response Team. The Crisis Response Coordinator must maintain documentation of contacts with these agencies.

E. Crisis Response Services will offer and provide mental health crisis response/intervention training to law enforcement agencies. The Crisis Response Coordinator must maintain documentation of the request, response and training provided.

F. Crisis Response Services will attempt to develop a close working relationship with all Chancery Courts and Clerks in the provider's catchment area. The Crisis Response Coordinator must maintain documentation of contacts with these agencies.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

19.4 Crisis Response Services Documentation Requirements

A. Crisis Response Services must maintain written documentation (i.e. crisis log or list) of all crisis response contacts (face-to-face and telephone contacts), including, at a minimum:

1. Identification of the individual in crisis.
2. Time and date contact was made.
3. Type of contact (face-to-face contact and/or telephone contact.)
4. The location of contact, if it was face-to-face.
5. Name of the staff member(s) addressing the emergency/crisis.

B. A Crisis Contact Summary as described in the DMH Record Guide must be completed for each individual in which Crisis Response Services are provided.

C. Crisis Response Services will submit data as determined and required by the Department of Mental Health.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 19.5 Crisis Stabilization Services – Crisis Stabilization Units

A. Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Stabilization Services must be designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Stabilization Services content may vary based on each individual's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

B. Crisis Stabilization Services may be provided to children/youth with serious emotional/behavioral disturbance or adults with a serious and persistent mental illness.

C. Children receiving Crisis Stabilization Services must be a minimum of six (6) years of age. Children/youth up to age eighteen (18) cannot be served in the same facility as adults.

D. Crisis Stabilization Services must be designed to accept admissions (voluntary and involuntary) twenty-four (24) hours per day, seven (7) days per week.

E. Crisis Stabilization Services must provide the following within twenty-four (24) hours of admission to determine the need for Crisis Stabilization Services and to rule out the presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition and/or illicit substance/medication use;

1. Initial assessment
2 Medical screening
3. Drug toxicology screening
4. Psychiatric consultation

F. Crisis Stabilization Services must consist of;

1. Evaluation
2. Observation
3. Supportive counseling
4. Substance abuse counseling
5. Individual, Group and Family Therapy
6. Targeted Case Management and/or Community Support Services
7. Family Education
8. Therapeutic Activities (i.e., recreational, psycho-educational, social/interpersonal)

G. Direct services (i.e., Supportive counseling, therapy, recreational, psycho-education, social/interpersonal activities) can be provided seven (7) days per week but must at a minimum be;

1. Provided five (5) days per week.
2. Provided five (5) hours per day.
3. Provided two (2) hours per day for children/youth if attending school.

H. A daily schedule must be maintained and posted in a prominent location. The schedule must show the entire day (24 hours).

I. Crisis Stabilization Services must also provide adequate nursing and psychiatric services to all individuals served. At a minimum, these services must be provided every seven (7) days (or more often if clinically indicated).

J. An initial individual therapy session must be provided to each individual admitted within the first seventy-two (72) hours of his/her admission.

K. Prior to discharge from Crisis Stabilization Services, an appointment must be made for the individual to begin or continue services from the local Community Mental Health Center or other mental health provider.

L. Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site director.

M. Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site mental health therapist.

N. Crisis Stabilization Services must maintain at least a one (1) direct service staff to four (4) residents ratio twenty-four (24) hours per day, seven (7) days per week. A Registered Nurse must be on-site during all shifts and may be counted in the required staffing ratio.

O. All Crisis Stabilization Services staff must successfully complete training and hold certification in a nationally recognized or DMH-Approved Program for managing aggressive or risk-to-self behavior.

P. The DMH only allows seclusion to be used in Crisis Stabilization Services with individuals over the age of eighteen (18.) Time-Out may be utilized for individuals under the age of 18.

Q. If a program uses a room for seclusion(s), the program must be inspected by DMH and obtain written approval of the use of such room from the DMH Review Committee prior to its use for seclusion. A room must meet the following minimum specifications in order to be considered for approval by the DMH for use in seclusion:

1. Be constructed and located to allow visual and auditory supervision of the individual
2. The dimensions of the room must be at least forty-eight (48) square feet
3. Be suicide resistant and have break resistant glass (if any is utilized in the room or door to the room).

R. CSU providers utilizing seclusion must establish and implement written policies and procedures specifying appropriate use of seclusion. The policies and procedures must include, at a minimum:

1. Clearly define seclusion and the appropriate conditions and documentation associated with its use. Seclusion is defined as behavioral control technique involving locked isolation. This does not include a time-out.
2. Require that seclusion is used only in emergencies to protect the individual from injuring himself/herself or others. “Emergency” is defined as a situation where the individual’s behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, staff, or others.

3. Require that seclusion is used only when all other less restrictive alternatives have been determined to be ineffective to protect the individual or others from harm and documented in the individual's case record.
4. Require that seclusion is used only in accordance with the order of a physician or other licensed independent practitioner, as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider. This order must be documented in the case record. The following requirements must be addressed in the policies and procedures regarding the use and implementation of seclusion and implementation (as applicable) and be documented in the individual case record:

   (a) Orders for the use of seclusion must never be written as a standing order or on an as needed basis (that is, PRN)
   (b) The treating physician must be consulted as soon as possible, if the seclusion is not ordered by the individual's treating physician
   (c) A physician or other licensed independent practitioner must see and evaluate the need for seclusion within one (1) hour after the initiation of seclusion
   (d) Each written order for seclusion must be limited to four (4) hours. After the original order expires, a physician or licensed independent practitioner (as permitted by State licensure rules/regulations governing scope of practice of the independent practitioner and the provider) must see and assess the individual in seclusion before issuing a new order
   (e) Seclusion must be in accordance with a written modification to the Individual Service Plan of the individual being served
   (f) Seclusion must be implemented in the least restrictive manner possible
   (g) Seclusion must be in accordance with safe, appropriate techniques
   (h) Seclusion must be ended at the earliest possible time.

5. Requirements that seclusion is not used as a form of punishment, coercion, or staff convenience.
6. Requirements that all staff which have direct contact with individuals being served must have ongoing education and training in the proper, safe use of seclusion.
7. Requirements that trained staff (as described above) observe the individual and record such observation at intervals of fifteen (15) minutes or less and that they record the observation in a behavior management log that is maintained in the case record of the individual being served.
8. Requirements that the original authorization order of the seclusion may only be renewed for up to a total of twenty-four (24) hours by a licensed physician or licensed independent practitioner, if less restrictive measures have failed.

S. DMH states, "Providers are prohibited from the use of chemical restraints." A chemical restraint incapacitates an individual rendering them unable to function as a result of the medication. However, a therapeutic agent may be used to treat behavioral symptoms during a crisis. The therapeutic agent can be used to calm agitation, to help the individual concentrate, and make him/her more accessible to interpersonal intervention. Regardless of indication, medication administration during a crisis must be preceded by an

appropriate clinical assessment and documentation of the assessment must be maintained in the individual's record.

T. An "as needed," prescription for a therapeutic agent at admission for all individuals is prohibited. If the clinical assessment at admission indicates the need for a therapeutic agent then it may be administered. A verbal approval for the use of a therapeutic agent by the psychiatrist or psychiatric nurse practitioner must be documented in the record as soon as possible.

U. Smoking is not permitted within ten (10) feet of the entrance of a Crisis Stabilization Unit.

V. All Crisis Stabilization Service providers must conduct an assessment, at least annually, of the following;

1. Evaluation of the level of observation that is required for all individuals receiving services at the Crisis Stabilization Unit. Policy and procedures should allow for assessment upon admission and at regular intervals during the course of treatment. If the assessment or clinical judgement indicates a greater frequency of observation is necessary, policies and procedures should reflect those practices. Policy and procedures should identify who is responsible for conducting the assessment (s).
2. Review of the physical environment of care to assess for potential risks and /or access to lethal means. Mitigation efforts must be put into place when risks are identified.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 19.6 Environment and Safety for Crisis Stabilization Units

A. This rule applies to environmental and safety requirements that are in addition to or more stringent than the requirements in Chapter 13 and are specific to Crisis Stabilization Units. CSUs must have procedures in place to routinely assess for access to potential lethal means and eliminate such risks.

B. The provider must assign, maintain and document on-site staff coverage twenty-four (24) hours a day and seven (7) days a week with a staff member designated as responsible for the program at all times and male/female staff coverage when necessary.

C. All providers must ensure that programs have furnishings that are safe, comfortable, appropriate, and adequate.

D. All providers must ensure adequate visiting areas are provided for residents and visitors.

E. All providers must ensure the laundry room has an exterior ventilation system for the clothes dryer.

F. All providers must have separate storage areas for:

1. Sanitary linen;
2. Food (Food supplies cannot be stored on the floor); and
3. Cleaning supplies.

G. All providers must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

H. All CSUs of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system;

I. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas;

J. CSUs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas;

K. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom;

L. Two (2) means of exit per common area must be provided and must be readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition.

M. CSUs must have the capacity to monitor unauthorized entrance, egress, or movement through the facility; and,

N. CSUs must have emergency exit doors operated by a magnetic/electronic (or similar) release system. This system must be in place for all doors with signage identifying the door as an emergency exit. The system must be in a readily accessible and secure location that only staff can access.

O. CSU bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor.

P. CSU bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

Q. CSU bedrooms must house no more than two (2) persons each;

R. CSU bedrooms must be appropriately furnished with a minimum of a single bed per resident, an adequate storage must be provided for each resident;

S. CSU bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances;

T. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and

U. Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

V. All CSUs must have a bathroom(s) with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

W. All CSUs must ensure bathtubs and showers are equipped with suicide resistant:

1. Soap dishes;
2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

X. Providers must develop policies regarding pets and animals on the premises for all community living programs.

Y. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals receiving services as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 19.7 Crisis Stabilization Unit Orientation

A. In addition to information contained in the provider's policy and procedure manual, providers of Crisis Stabilization Services must develop an orientation package which includes policies and procedures for the provision of Crisis Stabilization Services. The orientation package is to be provided to the individual/parent/legal representative during

orientation. Orientation may need to be delayed until the individual is stable enough to comprehend the information being provided.

B. All providers of Crisis Stabilization Services must document that each individual (and/or parent/guardian) being served is provided with an orientation as soon as it is appropriate based on the functioning of the individual.

C. The service and site-specific orientation package must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative.

D. Crisis Stabilization Services providers must have a written plan for providing the orientation package information in a individual's language of choice when necessary.

E. The Crisis Stabilization Services' orientation package must not simply be a book of rules. The orientation package must include the expectations of Crisis Stabilization Services and how the individual can be successful in the service.

F. At a minimum, the Crisis Stabilization Services' orientation package must address the following:

1. A person friendly, person first definition and description of the service being provided;
2. The philosophy, purpose and overall goals of the service
3. A description of how Crisis Stabilization Services addresses the following items, to include but not limited to:
   (a) Visitation guidelines (as they apply to family, significant others, friends and other visitors).
      (1) Individual's right to define their family and support systems for visitation purposes unless clinically/socially contraindicated
      (2) All actions regarding visitors (restrictions, defining individual and family support systems, etc.) must be documented in the individual's case record
      (3) Visitation rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.
   (b) Daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated
      (1) Any restrictions on private telephone use must be reviewed daily
      (2) All actions regarding restrictions of outside communication must be documented in the case record
      (3) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.
   (c) Dating
   (d) Off-site activities
   (e) Housekeeping tasks
   (f) Use of alcohol, tobacco and other drugs
   (g) Respecting the rights of other residents' privacy, safety, health and choices.

4. Policy regarding the search of the individual's room, person and/or possessions to include but not limited to;
   A. Circumstances in which a search may occur;
   B. Staff designated to authorize searches;
   C. Documentation of searches; and
   D. Consequences of discovery of prohibited items.
5. Policy regarding screening for prohibited/illegal substances to include but not limited to:
   (a) Circumstances in which screens may occur;
   (b) Staff designated to authorize screening;
   (c) Documentation of screening;
   (d) Consequences of positive screening of prohibited substances;
   (e) Consequences of refusing to submit to a screening; and
   (f) Process for individuals to confidentially report the use of prohibited substances prior to being screened.
6. Methods for assisting individuals in arranging and accessing emergency medical and dental care
   (a) Agreements with local physicians, hospitals and dentists to provide emergency care
   (b) Process for gaining permission from parent/guardian, if necessary.

G. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights

H. Determination of the need for and development, implementation and supervision of behavior change/management programs;

I. Description of how risks to health and safety of individuals in the program are assessed and the mitigation strategies put in place as a result of assessment; and,

J. Criteria for termination\discharge from Crisis Stabilization Services.

K. Providers of Crisis Stabilization Services must also address:

1. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided. This must include development of a menu that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.
2. Personal hygiene care and grooming, including any assistance that might be needed;
3. Medication management (including storing and dispensing); and,
4. Prevention of and protection from infection, including communicable diseases.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 19.8 ID/DD Waiver Crisis Intervention Services

A. Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or others and/or may result in the individual's removal from his/her current living arrangement.

B. Crisis Intervention Services are used in situations in which the need is immediate and exceeds the scope of Behavior Support Services.

C. This service is provided on a 1:1 staff to individual ratio.

D. There are three models and primary service locations: 1) Crisis Intervention in the individual's home 2) Crisis Intervention provided in an alternate community living setting or 3) Crisis Intervention provided in the individual's usual day setting.

   1. Individual's home- The provider will provide or coordinate support services with the individual's community living and day services provider(s). These services will, to the greatest extent possible, allow the individual to continue to follow his/her daily routine in the service setting, with accommodations consistent with the Crisis Intervention Plan and the individual's current behaviors. The Crisis Intervention Plan indicates any adaptations/changes needed in the environments in which the individual typically spends his/her days. The Crisis Intervention staff will train and model activities and methods for day and community living staff, family members and other caregivers in order minimize the current crisis as well as prevent future occurrences.

   2. Alternate residential setting- In the event an individual needs to receive Crisis Intervention services in a setting away from his/her primary residence, the provider must have pre-arranged for such a setting to be available. This may be an apartment, motel or a bedroom at a different DMH certified residence. The Crisis Intervention staff, to the greatest extent possible, maintains the individual's daily routine and follows the Crisis Intervention Plan to transition the individual back to his/her primary residence. The Crisis Intervention Plan indicates any adaptations/changes needed in the environments in which the individual typically spends his/her days.

   3. Individual's usual day setting- Crisis Intervention staff will deliver services in such a way as to maintain the individual's normal routine to the maximum extent possible, including direct support during Day Services-Adult, Prevocational Services, or Supported Employment. Other ID/DD Waiver services cannot be reimbursed while someone is receiving Crisis Intervention Services.

E. The provider must develop policies and procedures for locating someone to an alternate residential setting(s). This includes the type of location, whether individuals will be alone or with others, and plans for transporting individuals. The policies and procedures must include a primary and secondary means for providing an alternate residential setting(s). These settings must be equipped with all items necessary to create a home like environment for the individual.

F. The provider must have an on-call system that operates 24 hours a day, seven (7) days per week to ensure there is sufficient staff available to respond to crises.

G. Providers of Crisis Intervention shall consist of a team (see Rule 11.4 for qualifications) which must include:

1. Licensed Psychologist
2. Program Director
3. QIDP
4. Direct service staff

H. Crisis Intervention Services are approved on an individual's Plan of Services and Supports when there is a reasonable expectation, based on past occurrences or immediate situational circumstances in which the individual is at risk of causing physical harm to him/herself, causing physical harm to others, damaging property, eloping, or being unable to control him/herself in a manner that allows participation in usual activities of daily life. The provider will be chosen at the time the service is approved on the Plan of Services and Supports; therefore, if a crisis arises, the provider can be dispatched immediately.

I. Upon receiving information that someone is in need of Crisis Intervention, the provider immediately sends trained staff to the individual to assess the situation and provide direct intensive support when an individual is physically aggressive or there is concern that the individual may take actions that threaten the health and safety of self and others.

J. As soon as is feasible, the individual must be evaluated by medical personnel to determine if there are any physical/medication factors affecting his/her behavior.

K. When the immediate crisis is stabilized, appropriately qualified staff:

1. Continue analyzing the psychological, social and ecological components of the extreme dysfunctional behavior or other factors contributing to the crisis
2. Assess which components are the most effective targets of intervention for the short-term amelioration of the crisis
3. Develop and write a Crisis Intervention Plan
4. Consult and, in some cases, negotiate with those connected to the crisis in order to implement planned interventions, and follow-up to ensure positive outcomes from interventions or to make adjustments to interventions
5. Continue providing intensive direct supervision/support
6. Assist the individual with self-care when the primary caregiver is unable to do so because of the nature of the individual's crisis situation
7. Directly counsel or develop alternative positive experiences for individuals while planning for the phase out of Crisis Intervention services and return of the individual to his/her living arrangement, if applicable

8. Train staff and other caregivers who normally support the individual in order to remediate the current crisis as well as to support the individual long term once the crisis has stabilized in order to prevent a reoccurrence.

L. Crisis Intervention staff may remain with the person 24/7 until the crisis is resolved; Crisis Intervention is authorized for up to 24 hours per day in seven (7) day segments with the goal being a phase out of services in a manner which ensures the health and welfare of the individual and those around him/her. Additional seven (7) day segments will be authorized, depending on individual need and situational circumstances.

M. Episodic Crisis Intervention is provided in short term (less than 24 hours) segments and is intended to address crises such as elopement, immediate harm to self or others, damage to property, etc. that can be managed through less intensive measures than daily Crisis Intervention.

N. If an individual requires a higher level of supervision/support than can be safely provided through Crisis Intervention services, he/she will be appropriately referred to other more intensive services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 19.9 ID/DD Waiver Crisis Support Services

A. Crisis Support is provided in an ICF/IID and is used when an individual's behavior or family/primary caregiver situation becomes such that there is a need for immediate specialized services that exceed the capacity of Crisis Intervention or Behavior Support services.

B. Individuals cannot be admitted to an ICF/IID without prior approval from BIDD.

C. Crisis Support is provided a maximum of thirty (30) days. Additional days must be prior authorized by BIDD.

D. Providers must follow all applicable state and federal ICF/IID regulations related to the use of seclusion or restraint.

E. Individuals receiving Crisis Support services can be transitioned back to their regular daily activities/living arrangements, but other ID/DD Waiver services cannot be reimbursed while someone is receiving Crisis Support.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 20: Community Support Services

Rule 20.1 Community Support Services – General

A. Community Support Services provide an array of support services delivered by community-based, mobile Community Support Specialists. CSS are only provided by certified DMH/C and DMH/P providers. CSS are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work, family, community participation.

B. Community Support Services should be person-centered and focus on the individual's recovery and ability to succeed in the community; to identify and access needed services; and to show improvement in home, health, purpose and community. Community Support Services shall include the following:

1. Identification of strengths which will aid the individual in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.
2. Individual therapeutic interventions with a beneficiary that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.
3. Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals.
4. Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
5. Direct interventions in deescalating situations to prevent crisis.
6. Assisting an individual in accessing needed services such as medical, social, educational, transportation, housing, substance abuse, personal care, employment and other services that may be identified in the Recovery Support Plan as components of Health, Home, Purpose and Community.
7. Assisting the individual and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.
8. Relapse prevention and disease management strategies.
9. Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.
10. Facilitation of the Individual Service Plan and/or Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as important in the person's life.

C. Providers of CSS must, at a minimum:

1. Have a designated Director of CSS to supervise the provision of CSS.

2. Assign a full time, DMH Credentialed Community Support Specialist for each individual enrolled in the service.
3. Maintain a list of each Community Support Specialist's caseload that must be available for review by DMH staff.
4. Maintain a current, comprehensive file of available formal and informal supports that is readily accessible to all Community Support Specialists.
5. Electronically maintained resource information is permissible. This resource file must include at a minimum:
   (a) Name of entity
   (b) Eligibility requirements (if applicable)
   (c). Contact person
   (d) Services and supports available
   (e) Phone number.

D. The following priority groups of individuals with serious mental illness, children/youth with serious emotional disturbance and individuals with an intellectual or developmental disability must be offered CSS within fourteen (14) days of the date of his/her Initial Assessment. CSS must be provided within fourteen (14) days of the Initial Assessment unless the individual states, in writing, that he/she does not want to receive the service.

   1. Individuals discharged from an inpatient psychiatric facility;
   2. Individuals discharged from an institution;
   3. Individuals discharged or transferred from Crisis Stabilization Services; and
   4. Individuals referred from Emergency/Crisis Response Services.

E. Individuals with serious mental illness, serious emotional disturbance and/or an intellectual/developmental disability not included in these priority groups should be assessed to determine the need for CSS within thirty (30) days of his/her Initial Assessment. CSS must be provided within thirty (30) days of the Initial Assessment if the assessment indicates a need for such, unless the individual states, in writing, that he/she does not want to receive the service.

F. Caseloads of Community Support Specialists must not exceed eighty (80) individuals receiving services.

G. Frequency of the provision of Community Support Services should be based on the needs of the individual receiving the service.

H. The Recovery Support Plan must clearly state and justify the frequency of contact.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 20.2 Community Supports for Adults with SMI

Providers of Community Support Services for Adults with SMI must also adhere to Rule 20.1.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 20.3 Community Support Services for Children/Youth with SED

A. Providers of Community Support Services for Children/Youth with SED must also adhere to Rule 20.1.

B. Input from the parent(s)/legal representative(s) in the development of the Recovery Support Plan for children/youth must be documented.

C. The case load for a single Community Support Specialist providing services to children, youth, and transition-age youth enrolled in federal System of Care grants must not exceed twenty-five (25).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 20.4 Community Support Services for Individuals with Intellectual/Developmental Disabilities – Adults and Children

A. Providers of Community Support Services for Individuals with and IDD must also adhere to Rule 20.1.

B. Community Support Services for this population must target individuals who are dually diagnosed with a serious mental illness or serious emotional disturbance and an intellectual/developmental disability. Community Support Services for this population must focus on rehabilitation efforts that target an individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family; and community integration.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 21: Psychiatric/Physician Services

Rule 21.1 Psychiatric/Physician Services

A. Psychiatric/Physician's Services are services of a medical nature provided by medically trained staff to address medical conditions related to the individual's mental illness or emotional disturbance. Medical services include medication evaluation and monitoring, nurse assessment, and medication injection.

B. If indicated by the Initial Assessment, the following priority groups of individuals with serious mental illness, children/youth with serious emotional disturbance and individuals with an intellectual or developmental disability (if applicable) must be provided Psychiatric/Physician's Services within fourteen (14) days of the date of his/her Initial Assessment unless the individual states, in writing, that he/she does not want to receive the service. Appointment cancellations or "no shows" must be documented in the individual's case record.

   1. Individuals discharged from an inpatient psychiatric facility;
   2. Individuals discharged from an institution;
   3. Individuals discharged or transferred from Crisis Stabilization Services; and,
   4. Individuals referred from Crisis Response Services.

C. Medication Evaluation and Monitoring is the intentional face-to-face interaction between a physician or a nurse practitioner and an individual for the purpose of: assessing the need for psychotropic medication, prescribing medications, and regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety.

D. Nursing assessment takes place between a registered nurse and an individual for the purpose of assessing extra-pyramidal symptoms, medication history, medical history, progress on medication, current symptoms, progress or lack thereof since last contact and providing education to the individual and the family about the illness and the course of available treatment.

E. Medication injection is the process of a licensed practical nurse, registered nurse, physician, or nurse practitioner injecting an individual with prescribed psychotropic medication for the purpose of restoring, maintaining or improving the individual's role performance and/or mental health status.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 22: Outpatient Therapy Services

Rule 22.1 Psychotherapeutic Services

A. Outpatient Psychotherapeutic Services include initial assessment, and individual, family, group, and multi-family group therapies. Outpatient Psychotherapeutic Services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a mental health therapist, IDD therapist or A/D therapist (as appropriate to the population being served) and an individual, family or group where a therapeutic relationship is established to help resolve symptoms of a mental and/or emotional disturbance.

B. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and the individual receiving services.

C. Family Therapy shall consist of psychotherapy that takes place between a mental health therapist and an individual's family members with or without the presence of the individual. Family Therapy may also include others (DHS staff, foster family members, etc.) with whom the individual lives or has a family-like relationship. This service includes family psychotherapy and psychoeducation provided by a mental health therapist.

D. Group Therapy shall consist of psychotherapy that takes place between a mental health therapist and at least two (2) but no more than ten (10) children or at least two (2) but not more than twelve (12) adults at the same time. Possibilities include, but are not limited to, groups that focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

E. Multi-Family Group Therapy shall consist of psychotherapy that takes place between a mental health therapist and family members of at least two (2) different individuals receiving services, with or without the presence of the individual, directed toward the reduction/resolution of identified mental health problems so that the individual and/or their families may function more independently and competently in daily life. This service includes psychoeducational and family-to-family training.

F. Outpatient Psychotherapeutic services must be available and accessible at appropriate times and places to meet the needs of the population to be served. The provider must establish a regular schedule, with a minimum of three (3) hours weekly for the provision of Outpatient Psychotherapeutic services during evenings and/or weekends.

G. Providers utilizing Evidence Based Practices (EBP) or best practices in the provision of Outpatient Psychotherapeutic Services must show verification that staff members utilizing those practices have completed appropriate training or independent study as recommended by the developers of the model/practice for the practices being utilized.

H. For DMH/C providers of Outpatient Psychotherapeutic Services for Children/Youth: At least, one outpatient therapist must be offered to each public school district in the region served by the CMHC. If the school district does not accept the provider's offer to provide outpatient psychotherapeutic services, written documentation of the denial (for the current school year) by the school district superintendent must be on file at the CMHC for review by DMH personnel.

I. There must be written policies and procedures for:

1. Admission
2. Coordination with other services in which the individual is enrolled
3. Follow-up designed to minimize dropouts and maximize treatment compliance
4. Therapist assignments
5. Referral to other appropriate services as needed; and
6. Discharge planning.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 22.2 Intensive Outpatient Psychiatric Services for Children/Youth with SED

A. Intensive Outpatient Psychiatric (IOP-C/Y) services are defined as treatment provided in the home or community to children and youth with serious emotional disturbance up to the age of twenty-one (21) for family stabilization. Based on a wraparound model, this service is a time-limited, intensive family intervention intended to diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. The ultimate goal is to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).

B. In order to receive IOP services, individuals must meet all the following criteria:

1. The youth has been diagnosed by a psychiatrist or licensed psychologist in the past sixty (60) days with a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria for Serious Emotional Disturbance (SED) specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The primary diagnosis must be psychiatric.
2. The youth has a full scale IQ of sixty (60) or above (or, if IQ score is lower than sixty (60) and there is substantial evidence that the IQ score is suppressed due to psychiatric illness).
3. The evaluating psychiatrist or licensed psychologist advises that the youth meets criteria for PRTF level of care.
4. The youth needs specialized services and supports from multiple agencies including community support services or targeted case management, and an array of clinical interventions and family supports.

C. Providers of Intensive Outpatient Psychiatric Services must meet the following requirements:

1. Hold certification by DMH to provide Community Support Services and wraparound facilitation;
2. Have a psychiatrist on staff;
3. Have appropriate clinical staff to provide therapy services needed;
4. Coordinate services and needed supports with other providers and/or natural supports when appropriate and with consent;
5. Provide education on wellness, recovery and resiliency;
6. Providers must have procedures in place for twenty-four (24) hour, seven (7) days a week availability and response (inclusive of mobile crisis response services).

D. IOP-C/Y must be provided to children/youth based on the child/youth's needs as identified as a part of the wraparound or individual plan.

E. IOP-C/Y is an all-inclusive service designed to meet the clinical needs of the children/youth and families. Component parts of IOP must also be certified by DMH if applicable certification is available.

F. Each beneficiary receiving IOP-C/Y must have on file an individualized plan which describes the following:

1. Services to be provided;
2. Frequency of service provision;
3. Who provides each service and their qualifications;
4. Formal and informal supports available to the participant and family; and
5. Plan for anticipating, preventing and managing crises.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 22.3 Intensive Outpatient Programs for Adults with a Substance Use Disorder

A. The 10-week Intensive Outpatient Program for Individuals with a Substance Use Disorder (IOP-SUD) is a community-based outpatient program which provides an alternative to traditional Residential Treatment Services or hospital settings. The program is directed to adults 18 year or older who need services more intensive than traditional outpatient services, but who have less severe alcohol and other drug disorders than those typically addressed in Residential Treatment Services. The IOP-SUD allows individuals to continue to fulfill their obligations to family, job, and community while obtaining intensive treatment. IOP-SUD may be conducted during the day or at night in order to meet the needs of the Individuals being served.

B. IOP-SUD must be limited to twelve (12) individuals per session.

C. IOP-SUD must provide the following services:

1. Group therapy for a minimum of three (3) sessions per week for at least ten (10) weeks. Sessions times may vary but cannot be less than one hour and cannot exceed three hours daily. Individuals must receive and not exceed 9 total hours of group therapy per week. Groups may be of the following types: Psychoeducational groups, Skills-development groups, Drug or alcohol refusal training, Relapse prevention techniques, Assertiveness training, Stress management, Support groups (e.g., process-oriented recovery groups), Single-interest groups (can include gender issues, sexual orientation, criminal offense, and histories of physical and sexual abuse) family or couples groups.
2. Individual therapy at a minimum of one (1) counseling session, for a minimum of one hour, per week; and
3. Involvement of family to include no less than two (2) therapeutic family group sessions during the ten (10) week period, offered to meet the needs of the individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 22.4 Intensive Outpatient Programs for Adolescents with a Substance Use Disorder

A. Adolescent-Intensive Outpatient Program (A-IOP) is a community-based outpatient program which provides an alternative to traditional Residential Treatment Services or hospital settings. The program is directed to adolescents ages 12-18 who need services more intensive than traditional outpatient services, but who have less severe alcohol and other drug disorders than those typically addressed in Residential Treatment Services. The A-IOP allows individuals to continue to fulfill their obligations to family, job, school, and community while obtaining treatment. A-IOP is primarily conducted in the evening, but may be offered at in varying locations and times to suit the needs of the adolescents being served.

B. A-IOP must be limited to twelve (12) individuals per session.

C. A-IOP must provide the following services:

1. Group therapy must be offered over the course of at least 10 weeks for 6.5 hours per week. Times and locations for groups may vary based on the needs of the adolescents being served. Groups may be of the following types: Psychoeducational groups, Skills-development groups, Drug or alcohol refusal training, Relapse prevention techniques, Assertiveness training, Stress management, Support groups (e.g., process-oriented recovery groups), Single-interest groups (can include gender issues, sexual orientation, criminal offense, and histories of physical and sexual abuse) family or couples groups.
2. Individual therapy at a minimum of one (1) counseling session, for a minimum of one hour, per week; and

3. Involvement of family to include no less than two (2) therapeutic family group sessions during the ten (10) week period, offered to meet the needs of the individual.
4. Providers utilizing Evidence-Based Practices (EBP) or best practices in the provision of A-IOP must show verification that staff members utilizing those practices have completed appropriate training or independent study as recommended by the developers of the model/practice for the practices being utilized.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 23: Acute Partial Hospitalization Services for Children with SED, Adults with SMI and Partial Hospitalization Programs for Adults or Children with Substance Use Disorders

Rule 23.1 Acute Partial Hospitalization Services to Children with SED or Adults with SMI

A. Acute Partial Hospitalization Services (APH) provide medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. APH is designed to provide an alternative to inpatient hospitalization for such individuals or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. APH may be provided to children with serious emotional disturbance or adults with serious and persistent mental illness.

B. The APH program must be a part of a written comprehensive plan of crisis stabilization and community-based support services offered to individuals participating in the APH program that includes, at a minimum, family intervention, Targeted Case Management, medication monitoring, Crisis Response Services and Community Support Services. The APH program must be designed to assist individuals in making the transition from acute inpatient services, and/or serve as an alternative to inpatient care.

C. There must be written policies and procedures implemented for providing APH that include at a minimum:

   1. Admission criteria and procedures. These procedures must require that a physician conduct an admission evaluation and certify that the service is required to reduce or prevent inpatient services.
   2. Procedures requiring documented medical supervision and follow along with on-going evaluation of the medical status of the individual.
   3. Procedures requiring documented support services for families and significant others.
   4. Procedures implementing and documenting discharge criteria to include follow-up planning.

D. The staff for APH Services must include at each site a full time director who plans, coordinates, and evaluates the program.

E. APH Services staff must meet the following minimum requirements:

   1. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field must be on-site for six (6) or fewer persons for which the program is certified to serve. The staff can be the on-site Program Director if he/she is actively engaged in programmatic activities with individuals during all program hours.
   2. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field and at least one (1) staff with a minimum of a Bachelor's degree in a

mental health or related field when seven (7) through twelve (12) participants are served.

3. At least one (1) staff with a minimum of a Master's degree in a mental health or related field, at least one (1) staff with a minimum of a Bachelor's degree in a mental health or related field and least one (1) support staff when thirteen (13) through eighteen (18) participants are served in the program.

F. The APH Program must provide adequate nursing and psychiatric services to all individuals served. At a minimum, these services must be provided weekly (and more often if clinically indicated). Provision of these services must be documented through an implemented written procedure carried out by the provider or through contractual agreement.

G. Medical supervision and nursing services must be immediately available and accessible to the program during all hours of operation.

H. The APH Program can be operated seven (7) days per week, but must at minimum:

1. Operate three (3) days per week.
2. Operate four (4) hours per day, excluding transportation time.
3. Be available twelve (12) months per year.

I. The APH Program must be designed for a maximum number of eighteen (18) individuals with a maximum length of stay of thirty (30) service days. Service in the APH Program may only go beyond thirty (30) service days with written justification provided by the attending physician.

J. The provider must maintain a daily schedule of therapeutic activities to include individual, group, family, and other activities that are designed to provide intensive support to the individuals in the program and reduce acute symptomology.

K. The program must have sufficient space to accommodate the full range of program activities and services and must provide a minimum of fifty (50) square feet of multipurpose space for each individual served.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 23.2 Partial Hospitalization Program for Individuals with Substance Use Disorders

A. Partial Hospitalization Program (PHP) provides direct access to psychiatric, medical and laboratory services to meet the needs that warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. PHP is designed to provide an alternative to inpatient hospitalization for such individuals or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on need

but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

B. There must be written policies and procedures implemented for providing PHP that include at a minimum:

   1. Admission criteria and procedures. These procedures must require that a physician conduct an admission evaluation and certify that the service is required to reduce or prevent inpatient services.
   2. Procedures requiring documented medical supervision and follow along with on-going evaluation of the medical status of the individual.
   3. Procedures requiring documented support services for families and significant others.
   4. Procedures implementing and documenting discharge criteria to include follow-up planning.

C. The staff for PHP Services must include at each site a full time director who plans, coordinates, and evaluates the program.

D. PHP Services staff must have adequate substance use and addictive disorders experience and meet the following minimum educational requirements:

   1. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field experience must be on-site for six (6) or fewer persons for which the program is certified to serve. The staff can be the on-site Program Director if he/she is actively engaged in programmatic activities with individuals during all program hours.
   2. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field and at least one (1) staff with a minimum of a Bachelor's degree in a mental health or related field when seven (7) through twelve (12) participants are served.
   3. At least one (1) staff with a minimum of a Master's degree in a mental health or related field, at least one (1) staff with a minimum of a Bachelor's degree in a mental health or related field and least one (1) support staff when thirteen (13) through eighteen (18) participants are served in the program.

E. The PHP Program must provide adequate nursing and psychiatric services to all individuals served as needed. At a minimum, Psychiatric services must be offered at admission to the program. Services thereafter must be offered according to the individual's mental health condition.

F. Medical supervision and nursing services must be immediately available and accessible to the program during all hours of operation.

G. The PHP Program can be operated seven (7) days per week, but must at minimum:

   1. Operate four (4) days per week.

2. Operate four (4) hours per day, excluding transportation time.
3. Provide at least 20 hours of treatment service per week
4. Be available twelve (12) months per year.

H. The PHP Program must be designed for a maximum number of eighteen (18) individuals with a maximum length of stay of thirty (30) service days. Service in the PHP Program may only go beyond thirty (30) service days with written justification provided by the attending physician.

I. The provider must maintain a daily schedule of therapeutic activities to include individual, group, family, and other activities that are designed to provide intensive support to the individuals in the program.

J. The program must have sufficient space to accommodate the full range of program activities and services and must provide a minimum of fifty (50) square feet of multipurpose space for each individual served.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 24: Day Programs and Employment Related Programs for Adults with SMI

Rule 24.1 Psychosocial Rehabilitation Services

A. Psychosocial Rehabilitative Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

B. PSR services/programs must utilize systematic, curriculum based interventions for recovery skills development for participants. The curriculum based interventions must be evidence-based or recognized best practices in the field of mental health as recognized by SAMHSA. Curriculum based interventions must address the following outcomes for the individuals participating in PSR:

1. Increased knowledge about mental illnesses
2. Fewer relapses
3. Fewer re-hospitalizations
4. Reduced distress from symptoms
5. Increased consistent use of medications
6. Increased recovery supports to promote community living

C. The PSR systematic and curriculum based interventions must address the following core components:

1. Psychoeducation
2. Relapse Prevention
3. Coping Skills Training
4. Utilizing Resources and Supports (inclusive of crisis planning)

D. The PSR systematic and curriculum based interventions must, at a minimum, include the following topics:

1. Recovery strategies
2. Facts about mental illnesses
3. Building social supports
4. Using medications effectively
5. Drug and alcohol use

6. Reducing relapse
7. Coping with stress
8. Coping with problems and symptoms of mental illnesses
9. Self-advocacy

E. All individuals are required to have an Individual Recovery Action Plan (IRAP) or Wellness Recovery Action Plan (WRAP). Individuals must participate in setting goals and assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths, knowledge and needs in the individual's living, learning, social, and working environments.

F. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated recovery goals.

G. Documentation of therapeutic activities must be provided in weekly progress notes.

H. Individuals participating in PSR services may participate in the service up to five (5) hours per day up to five (5) days per week.

I. PSR services must have sufficient space to accommodate the full range of therapeutic activities and must provide at least fifty (50) square feet of space for each individual.

J. PSR services must be located in their own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other services/programs during hours of program operation.

K. The PSR program must include, at each site, a full time supervisor (see qualifications, Rule 11.3). A Director or Mental Health Therapist (see qualifications section) with the responsibility of therapeutic oversight must be on site a minimum of five (5) hours per week. The Program Director or Mental Health Therapist must plan, develop and oversee the use of an Evidenced Based curriculum implemented to address the needs of the individuals receiving PSR services. The chosen Evidence Based Curriculum must be implemented to fidelity. In addition to the minimum of five hours of on-site supervision, the Director or Mental Health Therapist must also participate in clinical staffing and/or Treatment Plan review for the individuals in the program(s) that he/she directs.

L. PSR services must maintain a minimum of one (1) qualified staff member to each twelve (12) or fewer individuals present in a PSR program. The supervisor may be included in this ratio.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.2 Senior Psychosocial Rehabilitation Services

A. Senior Psychosocial Rehabilitation Services (Senior PSR) are structured activities designed to support and enhance the ability of the elderly to function at the highest possible level of independence in the most integrated setting appropriate to their needs. The activities target the specific needs and concerns of the elderly, while aiming to improve reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Activities in the program are designed to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

B. Senior PSR must be designed to serve elderly persons with serious mental illness who need assistance in socialization, training for daily living skills, use of leisure time activities, or other structured assistance in activities of life.

C. No individuals under fifty (50) years of age can be considered for Senior PSR. All individuals in the program must voluntarily submit an application for the program, which must be maintained at each site in addition to his/her case record.

D. Senior PSR programs must have an average daily attendance at least five (5) individuals.

E. Each Senior PSR program must have a written schedule of daily activities on file, which must include group therapy, socialization activities, activities of daily living, and recreational activities.

F. Senior PSR must have activities and physical surroundings that are age appropriate.

G. The program must have sufficient space to accommodate the full range of program activities and services and must provide at least fifty (50) square feet of usable space for each individual.

H. Staff must be assigned full time to Senior PSR.

I. There must be a full time supervisor at each site (see qualifications, Rule 11.3). A Director or Mental Health Therapist (see qualifications section) with the responsibility of therapeutic oversight must be on site a minimum of five (5) hours per week. The Program Director (see qualifications, Rule 11.3) or Mental Health Therapist must plan, develop and oversee the use of systematic curriculum based interventions implemented to address the needs of the individuals receiving PSR services. In addition to the minimum of five hours of on-site supervision, the director or Mental Health Therapist must also participate in clinical staffing and/or Treatment Plan review for the individuals in the program(s) that he/she directs.

J. In addition to Rule 24.1.I, Senior PSR located in a Community Mental Health Center operated facility must meet the following:

1. There must be at least one staff member with minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who must be on-site and be actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor.
2. The staff person with a Bachelor's (who must be on-site and actively engaged in program activities during all programmatic hours and who may or may not be the on-site supervisor) is required for eight (8) or fewer people.
3. When the program is certified for nine (9) or more people, there must be another staff person for every eight (8) individuals.
4. Develop and implement plans to involve the individuals participating in Senior PSR in community activities to the maximum extent possible.
5. SPSR services must be provided in each location a minimum of three (3) days per week for a minimum of four (4) hours per day, excluding travel time.

K. In addition to Rule 24.1.I, Senior PSR located in a Licensed Nursing facility must meet the following:

1. There must be at least one staff member with minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who must be on-site and be actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor.
2. The staff person with a Bachelor's (who must be on-site and actively engaged in program activities during all programmatic hours and who may or may not be the on-site supervisor) is required for eight (8) or fewer people.
3. When the program is certified for nine (9) or more people, there must be another staff person for every eight (8) individuals for which the program is certified to serve.
4. DMH will accept verification of licensure from the MS State Department of Health as evidence that programs are addressing and meeting requirements for environment and safety.
5. SPSR services must be provided in each location a minimum of three (3) days per week for a minimum of two (2) hours per day, excluding travel time.
6. Individuals receiving Senior PSR services who are also Medicaid beneficiaries must also be authorized through the Preadmission Screening and Resident Review (PASRR) Rules.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.3 Training Requirements for Senior Psychosocial Rehabilitation Services

Senior Psychosocial Programs must conduct quarterly staff trainings that address the specialized needs of seniors, to include substance abuse issues. All Senior PSR staff are required to attend.

Training must be documented in the staff personnel record with a copy kept at the program location.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.4 Supported Employment Services for SMI

A. Supported Employment Services for SMI are provided to individuals with severe and persistent mental illnesses that have indicated that employment is one of their goals. The activities of Supported Employment help individuals achieve and sustain recovery. The ultimate goal of the supported employment program is to assist individuals with serious mental illness in discovering paths of self-sufficiency and recovery rather than disability and dependence.

B. Supported Employment Services will develop policies and procedures to provide and expand evidence-based supported employment services (such as the Individual Placement and Support (IPS) model), to adults with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. All adult clients with severe mental disorders are eligible, including dual disorders of substance abuse and mental illness.

C. Supported Employment Services must be voluntary.

D. Supported Employment Services will have no eligibility restrictions such as; job readiness, no substance abuse, no violent behavior, minimal intellectual functioning, or mild symptoms.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.5 Staffing Requirements for Supported Employment for SMI

A. Supported Employment Services must be delivered by a full-time Supported Employment Specialist. The Supported Employment Specialist will have at least a Bachelor's degree and will function as a part of a multidisciplinary mental health team.

B. Supported Employment sites must have the organizational capacity to provide at least (1) full-time equivalent (FTE) Supported Employment Specialist dedicated to employment services. The site may choose to have more than one Employment Specialist, but each position must be full-time to employment.

C. The Employment Specialist must be fully integrated into the treatment team. Progress notes must show collaboration among therapist, community support specialist, Doctor, etc.

D. The Employment Specialist will have an individual employment caseload not to exceed 20 individuals for any full-time Supported Employment Specialist.

E. Supported Employment Specialists must only provide employment services.

F. If an agency employs multiple Supported Employment Specialists they must have group supervision weekly to share information and help each other with cases. When necessary the Supported Employment Specialists can provide services, backup and support to another Specialist's caseload.

G. Supported Employment Services must have a designated supervisor. If the provider has more than ten Supported Employment Specialists, the supervisor must be full-time to the Supported Employment program.

H. The responsibilities of the Supported Employment supervisor must include but are not limited to;

1. Conduct weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives.
2. Communicate with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work.
3. Attend a meeting for each mental health treatment team on a quarterly basis.
4. Accompany Supported Employment Specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development.
5. Review current client outcomes with Employment Specialists at least quarterly and set treatment goals to improve program performance.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.6 Supported Employment for SMI Service Requirements

A. Any individual that determines that employment is a treatment goal must be referred to the Supported Employment Specialist. The provider must develop policies and procedures to design a referral system throughout the agency.

B. Supported Employment Services must:

1. Be individually tailored for each person to address the preferences and identified goals of each individual.

2. Be mobile and develop relationships with local businesses to establish employment opportunities.
3. Be delivered in an ongoing rather than time-limited basis to aid the process of recovery and ensure permanent employment.

C. Supported Employment Specialist will conduct job discovery with each individual served and find and maintain competitive work in the community. The Supported Employment Specialist and other members of the treatment team will offer on-going support to the individual to help ensure that employment is maintained.

D. A vocational assessment and profile will be completed, updated and maintained for each person utilizing the service.

E. Each program must maintain an active updated Local Employer Inventory for their area which includes;

1. Name
2. Type of business
3. Business mission
4. Hiring practices
5. Workforce aim
6. Location
7. Name of personnel director
8. Notes of interest, etc.

F. Each Supported Employment Specialist carries out all phases of vocational service, including engagement, assessment, job placement, and follow-up before step down to less intensive employment support from another mental health practitioner.

G. Supported Employment Specialists serve as members of one or two mental health treatment teams from which of the Employment Specialist's caseload is comprised.

H. Supported Employment Specialist will attend mental health treatment team meetings and participate actively in treatment team meetings with shared decision-making. The Employment Specialist should help the team assess employment possibilities for people who have not been referred to supported employment services.

I. The Supported Employment Specialist's office must be in close proximity to (or shared with) their mental health treatment team members.

J. The Supported Employment Specialist must collaborate with Vocational Rehabilitation counselors on a regular basis for the purpose of discussing shared clients and identifying potential referrals.

K. The agency's Quality Assurance process includes an explicit internal review of the SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale or until achieving high fidelity, and at least yearly thereafter by the DMH Fidelity Review Team. The agency's QA process uses the results of the fidelity assessment to improve SE implementation and sustainability.

L. Supported Employment Specialist or other MH practitioner must offer clients assistance in obtaining comprehensive, individualized work incentives planning by a specially trained work incentives planner prior to starting a job. They must also facilitate access to work incentives planning when clients need to make decisions about changes in work hours and pay. Clients are provided information and assistance about reporting earnings to SSA, housing programs, etc., depending on the person's benefits.

M. Supported Employment Specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability. Employment Specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment or presence of a psychiatric disability, or difficulty with anxiety, or unemployed for a period of time, etc.) and offers examples of what could be said to employers. Employment Specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after two months or if clients report difficulties on the job.)

N. Supported Employment Specialist must complete an initial vocational assessment, which can occur over 2-3 sessions and information is documented on a vocational profile form which includes preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. The vocational profile form is used to identify job types and work environments. The vocational profile form is updated with each new job experience. The assessment aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with the client's permission, family members and previous employers. Employment Specialists help clients learn from each job experiences and also works with the treatment team to analyze job loss, job problems and job successes.

O. The initial employment assessment and first face to face employer contact must occur within one month after services begin.

P. Employer contacts are based on clients' job preferences (relating to what they enjoy and their personal goals) and needs (including experience, ability, symptomatology, and health, etc., and how they affect a good job and setting match) rather than the job market (i.e., what jobs are readily available).

Q. Each employment specialist makes at least 6 face to-face employer contacts per week on behalf of the clients desiring employment. An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the client is present or not present. Client-specific and generic contacts are included.

Employment specialists must use a weekly tracking form to document employer contacts that is reviewed by the SE supervisor on a weekly basis.

R. Supported Employment Specialists must build relationships with employers through multiple visits in person to learn the needs of the employer, convey what the SE program offers to the employer, and describe client strengths that are a good match for the employer.

S. Supported Employment Specialists must assist clients in obtaining different types of jobs. Employment specialists provide job options that are and are in different settings

T. Supported Employment Specialists must assist clients in obtaining jobs with different employers.

U. Supported Employment Specialists must provide competitive job options that have permanent status rather than temporary or time-limited status, (e.g., TEPs). Competitive jobs pay at least minimum wage and are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)

V. Clients must receive different types of support that are based on the job, client preferences, work history, needs, etc. These supports are individualized and ongoing. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. The employment specialist helps people move on to more preferable jobs and also helps people with school or certified training programs.

W. Supported Employment Specialist must have face-to-face contact with client within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, as desired by the clients. Clients will be transitioned to step down job supports from a mental health worker following steady employment.

X. Vocational services such as engagement, job finding and follow-along supports are provided in natural community settings. Supported Employment Specialist must spend 70% or more time in community.

Y. Assertive engagement and outreach must be implemented by integrated treatment team. There must be evidence that all 6 strategies for engagement and outreach are used:

1. Service termination is not based on missed appointments or fixed time limits.
2. Systematic documentation of outreach attempts.
3. Engagement and outreach attempts made by integrated team members.
4. Multiple home/community visits.
5. Coordinated visits by employment specialist with integrated team member.
6. Connect with family, when applicable.

Z. Programs should organize and utilize Community Business Advisory Board as part of their community engagement and outreach efforts. At least one member of the provider's executive team must actively participate on the Board. Meetings must occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity.

AA. Programs should adhere to Data and Record Keeping Requirements for Good IPS Fidelity (according to guidelines).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 25: Day Services for Individuals with Alzheimer's and Other Dementia

Rule 25.1 Alzheimer's Day Services

A. The key elements of Alzheimer's Day Services are community based programs designed to meet the needs of adults with physical and psychosocial impairments, including memory loss, through individualized care plans. These structured, nonresidential programs provide a variety of social and related support services in a safe setting. Alzheimer's Day Services include Alzheimer's Day Programs and Alzheimer's Respite Programs. Alzheimer's Day Programs operate up to eight (8) hours per day, five (5) days per week. Alzheimer's Respite Programs operate up to twenty (20) hours per week with operating times to be determined by the provider. Alzheimer's Day Services focus on the strengths and abilities of individuals served by the program and ~~on~~ optimizing the health of the individuals. Alzheimer's Day Services provide a structured environment for individuals with Alzheimer's disease and related dementia; counseling for family members and/or other caregivers; and education and training for individuals providing services to those with Alzheimer's disease and related dementia and also to family members and/or caregivers; and respite. By supporting families and caregivers, Alzheimer's Day Services enable individuals with Alzheimer's disease and other dementia to live in the community.

B. Alzheimer's Day Services provide services for adults with physical and psychosocial impairments, who require supervision, including:

1. Individuals who have few or inadequate support systems.
2. Individuals who require assistance with activities of daily living (ADLs).
3. Individuals with memory loss and other cognitive impairment(s) resulting from Alzheimer's and other dementia that interfere with daily functioning.
4. Individuals who require assistance in overcoming the isolation associated with functional limitations or disabilities.
5. Individuals whose families and/care givers need respite.
6. Individuals who, without intervention, are at risk of premature long-term placement outside the home because of memory loss and/or other cognitive impairment(s).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 25.2 Alzheimer's Day Programs

A. Alzheimer's Day Programs must meet the following minimum staffing requirements:

1. A full-time program supervisor with at least a Bachelor's degree in a mental health, intellectual/developmental disabilities, social service or a related field and be under

the supervision of an individual with a Master's degree in mental health or intellectual/developmental disabilities, or a related field

2. A full-time Activities Coordinator with a minimum of a high school diploma or equivalent and at least one (1) year of experience in developing and conducting activities for the population to be served;
3. A full-time program assistant with a minimum of a high school diploma or equivalent and at least one (1) year of experience in working with adults in a health care or social service setting;
4. If volunteers are utilized, individuals who volunteer must demonstrate willingness to work with persons with Alzheimer's disease or related dementia, and they must successfully complete program orientation and training. The duties of volunteers must be mutually determined by volunteers and staff. Volunteers' duties, to be performed under the supervision of a staff member, can either supplement staff in established activities or provide additional services for which the volunteer has special talents.

B. In addition to General Orientation, Alzheimer's Day Program staff must attend training specific to address the needs of persons with cognitive impairment including communication techniques, redirection techniques, and activity interventions.

C. The ratio of staff to individuals served by the program must be at least one (1) full-time staff member per four (4) individuals served. The program supervisor may be included in the staffing ratio if he/she is on-site and actively engaged in the program.

D. The Alzheimer's Day Program must provide a balance of purposeful activities to meet individuals' interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual). Activities may include, but are not limited to:

1. Personal interaction
2. Individualized activities
3. Small and large group activities
4 Intergenerational experiences
5. Outdoor activities, as appropriate
6. Self-care activities
7. Culturally and ethnically relevant celebrations.

E. Individuals served by the program should be encouraged to take part in activities, but may choose not to do so or may choose another activity.

F. Individuals must be allowed time for rest and relaxation and to attend to personal and health care needs.

G. Activity opportunities must be available whenever the center is in operation. Activity opportunities are defined as structured opportunities for socialization and interaction that are available in large group, small group or individual formats. Opportunities for socialization should be individualized to meet the preferences of the participants.

H. Creative arts activities must be provided to improve or maintain physical, cognitive, and/or social functioning of individuals served by the program.

I. Family education and training must be made available at least monthly to family(ies) and/or caregiver(s) of individuals served by the program. This training must be designed to improve the well-being and functional level of the individuals served and/or families/caregivers. Provision of family education and training must be documented in the case record. A family education log must be kept by the Program Supervisor.

J. Opportunities for case staffing (including problem-solving as to how to respond to challenging scenarios involving individuals who receive services) between supervisory and all program staff must be made on a monthly basis or more frequently if determined necessary by the program supervisor.

K. The program must provide individualized assistance with and supervision of Activities of Daily Living (ADLs) in a safe and hygienic manner, with recognition of an individual's dignity and right to privacy, and in a manner that encourages individuals' maximum level of independence.

L. The program will ensure that each individual receives a minimum of one mid-morning snack, one nutritious noon meal, and one mid-afternoon snack, as well as adequate liquids throughout the day.

M. Each Alzheimer's Day Program location must adhere to the following:

1. Must have its own separate, identifiable space for all activities conducted during operational hours. The Alzheimer's Day Program must provide at least fifty (50) square feet of program space for multipurpose use for individuals served in the program.
2. A single program may serve no more than twenty (20) individuals at a time.
3. The facility must be flexible and adaptable to accommodate variations of activities (group and/individual) and services and to protect the privacy of individuals receiving services.
4. Identified space for individuals and/or family/caregivers to have private discussions with staff must be available.
5. Restrooms must be located as near the activity area(s) as possible.
6. A rest area for individuals served in the program must be available. That area must have a minimum of one (1) reclining chair per six (6) individuals served in the program.
7. An operable electronic security system that has the capacity to monitor unauthorized entrance or egress, or other movement through the entrance/exits must be utilized.
8. Outside space that is used for outdoor activities must be safe, accessible to indoor areas, and accessible to individuals with disability(ies) and shall include the following:
   (a) Must have secure, exterior pathway(s), a minimum of four (4) feet in width.

(b) Adequate outside seating.
(c) Exterior fencing, a minimum of six (6) feet in height, must enclose the outside area(s) where pathways and seating for individuals served by the program are provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 25.3 Alzheimer's Respite Program

A. Alzheimer's Respite Programs must meet the following minimum staffing requirements:

1. A full-time program supervisor with a Bachelor's degree in a mental health, intellectual/developmental disabilities, social service or related field and at least one (1) year of supervisory experience in a mental health, social or health service setting or two (2) years of comparable technical and human services training, with demonstrated competence and experience as a manager in a human services setting; this person can also serve as the Activities Coordinator;
2. A full-time Activities Coordinator with a minimum of a high school diploma or equivalent and at least one (1) year of experience in developing and conducting activities for the population to be served;
3. A full-time program assistant with a minimum of a high school diploma or equivalent and at least one (1) year of experience in working with adults in a health care or social service setting;
4. If volunteers are utilized, individuals who volunteer must demonstrate willingness to work with persons with Alzheimer's disease or related dementia, and they must successfully complete program orientation and training. The duties of volunteers must be mutually determined by volunteers and staff. Volunteers' duties, to be performed under the supervision of a staff member, can either supplement staff in established activities or provide additional services for which the volunteer has special talents.

B. In addition to General Orientation, Alzheimer's Day Program staff must attend training specific to address the needs of persons with cognitive impairment including communication techniques, redirection techniques, and activity interventions.

C. The ratio of staff to individuals served by the program must be at least one (1) full-time staff member per four (4) individuals served. The program supervisor may be included in the staffing ratio if he/she is on-site and actively engaged in the program. Volunteers may be included in the staff ratio provided that at least 2 program staff are on-site at the program.

D. The Alzheimer's Respite Program must provide a balance of purposeful activities to meet individuals' interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual). Activities may include, but are not limited to:

1. Personal interaction
2. Individualized activities
3. Small and large group activities
4 Intergenerational experiences
5. Outdoor activities, as appropriate
6. Self-care activities
7. Culturally and ethnically relevant celebrations.

E. Individuals served by the program should be encouraged to take part in activities, but may choose not to do so or may choose another activity.

F. Individuals must be allowed time for rest and relaxation and to attend to personal and health care needs.

G. Activity opportunities must be available whenever the center is in operation. Activity opportunities are defined as structured opportunities for socialization and interaction that are available in large group, small group or individual formats. Opportunities for socialization should be individualized to meet the preferences of the participants.

H. Creative arts activities must be provided to improve or maintain physical, cognitive, and/or social functioning of individuals served by the program.

I. Family education and training must be made available at least monthly to family(ies) and/or caregiver(s) of individuals served by the program. This training must be designed to improve the well-being and functional level of the individuals served and/or families/caregivers. Provision of family education and training must be documented in the case record. A family education log must be kept by the Program Supervisor.

J. Opportunities for case staffing (including problem-solving as to how to respond to challenging scenarios involving individuals who receive services) between supervisory and all program staff must be made on a monthly basis or more frequently if determined necessary by the program supervisor.

K. The program must provide individualized assistance with and supervision of Activities of Daily Living (ADLs) in a safe and hygienic manner, with recognition of an individual's dignity and right to privacy, and in a manner that encourages individuals' maximum level of independence.

L. The program will ensure that each individual receives a minimum of one snack and one nutritious noon meal, as well as adequate liquids throughout the day for programs that operate four (4) or less hours a day. Programs operating more than four (4) hours a day will ensure each individual receives a minimum of two (2) snacks and one nutritious noon meal, as well as adequate liquids throughout the day.

M. Each Alzheimer's Respite Program location must adhere to the following:

1. Must have its own separate, identifiable space for all activities conducted during operational hours. The Alzheimer's Respite Program must provide at least fifty (50) square feet of program space for multipurpose use for individuals served in the program.
2. A single program may serve no more than twenty (20) individuals at a time.
3. The facility must be flexible and adaptable to accommodate variations of activities (group and/individual) and services and to protect the privacy of individuals receiving services.
4. Identified space for individuals and/or family/caregivers to have private discussions with staff must be available.
5. Restrooms must be located as near the activity area(s) as possible.
6. A rest area for individuals served in the program must be available. That area must have a minimum of one (1) reclining chair per ten (10) individuals served in the program.
7. An operable electronic security system that has the capacity to monitor unauthorized entrance or egress, or other movement through the entrance/exits must be utilized.
8. The use of outside space is encouraged but not required. If a program utilizes outside space, the following guidelines shall be followed:
   (a) Must have secure, exterior pathway(s), a minimum of four (4) feet in width.
   (b) Adequate outside seating.
   (c) Exterior fencing, a minimum of six (6) feet in height, must enclose the outside area(s) where pathways and seating for individuals served by the program are provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 26: Day Programs for Children/Youth with SED

Rule 26.1 Day Treatment Services- General

A. Day Treatment Services are the most intensive outpatient services available to children/youth with SED. The services must provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment Services are a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community. Day Treatment Services are based on behavior management principle and include, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants at a particular site and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

B. At a minimum, one (1) Children's Day Treatment Program must be offered to each school district in the region served by each CMHC.

C. Children/youth must have the following in order to receive Day Treatment Services;

   1. An eligibility determination for one of the following: Serious Emotional Disturbance or Autism/Asperger's.
   2. A justification of the need for Day Treatment Services which must include documentation of the intensity and duration of problems, as part of the initial assessment or as part of a post-intake case staffing and at least annually thereafter. Documentation must also include the identification of at least three (3) specific behavioral criteria as set forth by DMH whose severity would prevent treatment in a less intensive environment.

D. Children must be between the ages of three – twenty-one (3-21) to be considered for enrollment in Day Treatment Services. Group composition must be both age and developmentally appropriate.

E. Each individual Day Treatment program must operate at a minimum of two (2) hours per day, two (2) days per week up to a maximum of five (5) hours per day, five (5) days per week. Each child/youth enrolled in Day Treatment Services must receive the service a minimum of four (4) hours per week.

F. To ensure each child's confidentiality, no children other than those enrolled in Day Treatment Services can be present in the room during the time Day Treatment Services are being provided.

G. Only one (1) Day Treatment Services program is allowed per room during the same time period.

H. Each individual Day Treatment Services program must operate under a separate DMH Certificate of Operation.

I. The Day Treatment Services Director or their designee (as approved by DMH) must:

1. Supervise, plan, coordinate, and evaluate Day Treatment Services. Supervision must be provided at least one continuous hour per month. This should include participation in clinical staffing and/or Treatment Plan review for the individuals in the program(s) that he/she implements or directs.
2. Provide at least thirty (30) continuous minutes of direct observation to each individual Day Treatment Services program at least quarterly. Documentation of the supervision/observation must be maintained for review.

J. The Day Treatment Specialist must participate in clinical staffing and/or Treatment Plan review for the individuals in the program that he/she serves as the primary clinical staff member.

K. The DMH Division of Certification must be notified immediately of any interruption of service with an individual Day Treatment program extending over thirty (30) days. If operation has been interrupted for sixty (60) calendar days, the DMH Certificate of Operation for that individual program must be returned to the DMH Division of Certification.

L. Day Treatment Services are intended to operate year-round and cannot be designed to operate solely during the summer months.

M. Day Treatment Service programs that are unable to provide services during a school's summer vacation will be allowed to hold that individual program's Certificate of Operation until it can be reopened the following school year. If the program has not reopened within sixty (60) calendar days from the first day of the school year, the Certificate of Operation must be returned to DMH Division of Certification.

N. Individual Day Treatment Service programs that do not meet during summer vacation must offer services (i.e. Community Support Services, outpatient therapy, etc.) for the child/youth to the parent(s)/legal representative(s) for the period Day Treatment Services are temporarily not in operation. Documentation must be maintained in each child/youth's record that availability of other services was explained and offered to the parent(s)/legal representative(s).

O. Individual Day Treatment programs operated in a school must ensure that Day Treatment Services continue to adhere to all DMH Operational Standards for MH/IDD/SUD Community Service Providers for this service. Day Treatment Services are a separate program from educational programs which must meet applicable State Department of Education standards and regulations. Day Treatment Services and educational services may not be provided concurrently.

P. Each Day Treatment program must be designed and conducted as a therapeutic milieu as evidenced by the use of a curriculum approved by the DMH and must include, but not be limited to, such skill areas as functional living skills, socialization or social skills, problem-solving, conflict resolution, self-esteem improvement, anger control and impulse control. The approved curriculum must be kept on site. All activities and strategies implemented must be therapeutic, age appropriate, developmentally appropriate and directly related to the objectives in each child/youth's Individual Service Plan.

Q. All Day Treatment Programs must include the involvement of the family or individuals acting in loco parentis as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

R. Each Day Treatment Program must operate with a minimum of four (4) and a maximum of ten (10) children/youth. A Day Treatment roll/roster cannot exceed ten (10) children/youth per program.

S. Day Treatment Programs developed and designed to serve primarily children/youth with a diagnosis of Autism shall not include more than four (4) children/youth with a diagnosis of Autism.

T. In order to participate in the Day Treatment program, a child or youth must be on the permanent roster for the program. They shall not participate on an intermittent basis.

U. Each Day Treatment Program must have a monthly Master Schedule on file at each location to include, at a minimum, the specific skill areas being addressed each day and the specific times these skill areas are being addressed. Skill area activities shown on the Master Schedule must be curriculum-specific.

V. Each Day Treatment Program must comply with the following:

1. A minimum of twenty (20) square feet of usable space per child/youth.
2. In cases of programs located in a school, the mental health provider is responsible for ensuring that the school district provides a site or facility that meets all DMH Health and Safety requirements. Programs that are conducted in space that is currently accredited by the Mississippi Department of Education will be considered as meeting all Environment/Safety standards.
3. Furnishings, equipment, square footage and other aspects of the Day Treatment Program environment must be age-appropriate, developmentally appropriate, and therapeutic in nature.

W. The ratio of staff to children/youth receiving services in each Day Treatment Program will be maintained at a minimum ratio of two on-site persons for a minimum of four (4) up to a maximum of ten (10) children/youth per program. Each program must be led by a Day Treatment Specialist. Day Treatment Assistants serve as the second needed staff in this ratio.

X. For all children/youth participating in Day Treatment Programs, there must be documentation of plans for transitioning a child to a less intensive therapeutic service. This documentation must be a part of each child's Individual Service Plan and/or case staffing. Transition planning should be initiated when the child begins to receive Day Treatment Services and must be documented within one (1) month of the child's start date for the service.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 26.2 Day Treatment Services for Pre-K

A. In addition to Rule 27.1, the standards that follow pertain to providers of Day Treatment Services that serve children 3-5 years of age who are identified as having a serious emotional disturbance.

B. All children must be signed in and out of the program by a parent/legal representative. If a child is being transported by the program staff, the parent/legal representative must sign when they put the child on and take the child off of the van. The parent/legal representative must sign their full name along with the time. If the child is to be signed in/out by any person other than the parent/legal representative, written permission from the parent/legal representative must be in the child's record. Sign In/Out documentation must be available for review.

C. Chairs and tables used in the room where Day Treatment Services are provided must be appropriate to the size and age of the children. This furniture must be kept clean with frequent disinfection.

D. Individual hooks or compartments must be provided for each child for hanging or storing outer and/or extra clothing. Individual hooks or compartments must be spaced well apart so that clothes do not touch those of another child. Each child must have an extra change of properly sized and season-appropriate clothes stored at the program at all times.

E. All children participating in Day Treatment Services must be age-appropriately immunized and must have a Mississippi State Department of Health Certificate of Immunization Compliance on file.

F. Any child who is suspected of having a contagious condition must be removed from the room where Day Treatment Services are being provided and sent home with their parent/legal representative as soon as possible. The child will not be allowed to return to the Day Treatment program until they have been certified by a physician as no longer being contagious. Conditions that would require exclusion from the program include fever, diarrhea, vomiting, rash, sore throat if accompanied by a fever, and/or eye discharge.

G. During the hours the Day Treatment Program is in operation, children must be offered adequate and nutritious meals and snacks. Menus must be available for review.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 27: IDD Day and Employment-Related Programs

Rule 27.1 Day Services – Adult

A. Day Services-Adult is the provision of regularly scheduled, individualized activities in a non-residential setting, separate from the participant's private residence or other residential living arrangements. Group and individual participation in activities that include daily living and other skills that enhance community participation and meaningful days for each individual are provided. Personal choice of activities as well as food, community participation, etc. is required and must be documented and maintained in each person's record.

B. Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice. Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices including what he/she does during the day and with whom they interact.

C. Day Services-Adult must have a community component that is individualized and based upon the choices of each person. Community participation activities must be offered to the same degree of access as someone not receiving ID/DD Waiver services. Community integration can be provided individually or in groups of up to three (3) people.

D. Community integration opportunities must be offered to each individual at least weekly and address at least one of the following:

   1. Activities which address daily living skills
   2. Activities which address leisure/social/other community activities and events.

E. Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.

F. Transportation must be provided to and from the program and for community participation activities.

G. Day Services-Adult includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day.

H. A private changing/dressing area must be provided to ensure the dignity of each individual.

I. All supplies and equipment must be appropriate for adults, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired.

J. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events, both at the certified site and in the community.

K. Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports.

L. Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.

M. The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be offered choices about what they eat and drink.

N. Each individual must have an Activity Support Plan that is developed based on his/her Plan of Services and Supports.

O. Individuals receiving Day Services-Adult may also receive Prevocational, Supported Employment, or Job Discovery services but not at the same time of the day.

P. The program must be in operation at least five (5) days per week, six (6) hours per day. The number hours of service is based on the individual's approved Plan of Services and Supports.

Q. There must be a minimum of fifty (50) square feet of usable space per every person in the program. Additional square footage may be required based on the needs of an individual.

R. Day Services-Adult activities must be distinct from Prevocational Services activities. Community participation activities cannot be comprised of individuals receiving Day Services-Adult with those receiving Prevocational Services. Day Habilitation and Day Services adult can be provided in the same area of a building and community participation activities can be conducted jointly.

S. Staffing ratios are based upon each person's Inventory for Client and Agency Planning (ICAP) score.

T. Individuals must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

U. Day Services-Adult does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

V. The program must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving ID/DD Waiver services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 27.2 Community Respite

A. Community Respite is provided in a DMH certified community setting that is not a private residence and is designed to provide caregivers an avenue of receiving respite while the individual is in a setting other than his/her home.

B. Community Respite is designed to provide caregivers a break from constant care giving and provide the individual with a place to go which has scheduled activities to address individual preferences/requirements.

C. The Community Respite provider must assist the individual with toileting and other hygiene needs.

D. Individuals must be offered and provided choices about snacks and drinks. There must be meals available if Community Respite is provided during a normal mealtime such as breakfast, lunch or dinner.

E. For every eight (8) individuals served, there must be at least two (2) staff actively engaged in program activities. One of these staff may be the on-site supervisor.

F. Individuals receiving Community Respite cannot be left unattended at any time.

G. Community Respite cannot be provided overnight.

H. Community Respite is not used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adult, Prevocational Services, or services provided through the school system.

I. Individuals who receive Host Home Services, Supervised Living, Shared Supported Living or Supported Living cannot receive Community Respite.

J. All supplies and equipment must be age appropriate, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired.

K. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events.

L. Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports.

M. Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.

N. Adults and children cannot be served together in the same area of the building. There must be a clear separation of space and staff.

O. The program must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving Home and Community Based Services (HCBS) services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 27.3 Prevocational Services

A. Prevocational Services provide the meaningful day activities of learning and work experiences, including volunteer work, where the individual can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings.

B. Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the individual and his/her team.

C. Individuals receiving Prevocational Services must have employment related outcomes in their Plan of Services and Supports; the general habilitation activities must be designed to support such employment outcome.

D. Prevocational Services must enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines.

E. Services are intended to develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples include but are not limited to:

1. Ability to communicate effectively with supervisors, coworkers and customers
2. Generally accepted community workplace conduct and dress
3. Ability to follow directions; ability to attend to tasks
4. Workplace problem solving skills and strategies
5. General workplace safety and mobility training
6. Attention span
7. Motor skills
8. Interpersonal relations

F. Participation in Prevocational Services is not a prerequisite for Supported Employment. An individual receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force.

G. Prevocational Services may be furnished in a variety of locations in the community and

are not limited to fixed program locations.

H. Community job exploration activities must be offered to each individual at least one time per month and be provided individually or in groups of up to three (3) people. Documentation of the choice to participate must be documented in each individual's record. Individuals who require one-on-one assistance must be included in community job exploration activities. Community participation activities must be offered to the same degree of access as someone not receiving services.

I. Transportation must be provided to and from the program and for community integration/job exploration.

J. Any individual receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the individual must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor. Services must be time limited with a written plan. The plan must include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.

K. At least annually, providers will conduct an orientation informing individuals about Supported Employment and other competitive employment opportunities in the community. This documentation must be maintained on site. Representative(s) from the Mississippi Department of Rehabilitation Services must be invited to participate in the orientation.

L. Personal care assistance from staff must be a component of Prevocational Services. Individuals cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene.

M. Mobile crews, enclaves and entrepreneurial models that do not meet the definition of Supported Employment and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site and be documented as part of the individual plan.

N. There must be a minimum of fifty (50) square feet of usable space per individual receiving services in the service area. Additional square footage may be required based on the needs of an individual.

O. The program must be in operation a minimum of five (5) days per week, six (6) hours per day. The number hours of service is based on an individual's approved Plan of Services and Supports.

P. The program must ensure it will make available lunch and/or snacks for individuals who do not bring their own.

Q. Individuals receiving Prevocational Services may also receive Day Services-Adult, or Job Discovery and/or Supported Employment, but not at the same time of day.

R. Individuals must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

S. Documentation is maintained that the service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq).

T. Prevocational Services activities must be distinct from other service activities. Additionally, community participation activities cannot be comprised of individuals receiving Prevocational Services and individuals receiving another service.

U. Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices, including but not limited to daily activities, physical environment and with whom they interact.

V. A private changing/dressing area must be provided to ensure the dignity of each individual.

W. Individuals aging out of school services must be referred to the Mississippi Department of Rehabilitation Services and exhaust those Supported Employment benefits before being able to enroll in Prevocational Services.

X. The amount of staff supervision someone receives is based on tiered levels of support determined by a person's score on the Inventory for Client and Agency Planning (ICAP).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 27.4 Job Discovery

A. Job Discovery includes, but is not limited to, the following types of person-centered services:

1. Face-to-face interviews that include a review of current and previous supports and services
2. Assisting the individual with volunteerism, self-determination and self-advocacy
3. Identifying support needs
4. Developing a plan for achieving integrated employment
5. Job exploration
6. Job shadowing
7. Internships
8. Employment (informational) seeking skills; current labor market
9. Interviewing skills
10. Job and task analysis activities
11. Job negotiation
12. Employment preparation (i.e. resume development, work procedures, soft skills)

13. Business plan development for self-employment.
14. Environmental and work culture assessments

B. Job Discovery must include:

1. Facilitation of a meeting held prior to discovery with the individual and family/friends as appropriate, which describes the job discovery process and its ultimate outcome of securing a community job for the job seeker.
2. Visit(s) to the individual's home (if invited; if not, another location) for the purposes of gaining information about routines, hobbies, family supports, activities and other areas related to a person's living situation.
3. Observation of the neighborhood/areas/local community near the individual's home to determine nearby employment, services, transportation, sidewalks and other safety concerns.
4. Interviews with two (2) to three (3) persons, both paid and not paid to deliver services, who know the individual well and are generally active in his/her life.
5. Observations of the individual as he/she participates in typical life activities outside of their home. At least one (1) observation is required.
6. Participation with the individual as he/she participates in typical life activities outside the home. At least two (2) activities are required.
7. Participation in a familiar activity in which the individual is at his/her best and most competent. At least one (1) activity is required.
8. Participation in a new activity in which the individual is interested in participating but has never had the opportunity to do so. At least one (1) activity is required.
9. Review of existing records and documents.
10. Development of discovery notes, Discovery Logs, and photos along with collecting other information that will be useful in development of the individual's Discovery Profile.
11. Development of the Discovery Profile document.

C. Job Discovery is intended to be time-limited; it cannot exceed twenty (20) hours of service over a three (3) month period.

D. The Development of the Discovery Profile results in a person centered, strength based profile and the development of an Employment/Career Plan.

E. Individual staff must receive or participate in Customized Employment training as specified by DMH before providing Job Discovery services.

F. Individuals who are currently employed or who receiving Supported Employment Services cannot receive Job Discovery services.

G. An Individual cannot receive Prevocational Services or Day Services-Adult at the same time of day as Job Discovery.

H. Persons eligible for Job Discovery include:

1. Someone who is an adult (age 21) and has never worked.
2. Someone who has previously had two (2) or more unsuccessful employment placements.
3. Someone who is leaving a nursing facility or ICF/IID.
4. Someone who has been in a Prevocational or Work Activity Program and has never had community employment.
5. Someone with multiple disabilities who has previously or never been successful in obtaining community employment.
6. Someone who cannot represent him/herself without assistance and who has previously or never been successful in obtaining community employment.
7. Someone at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 27.5 Supported Employment for IDD

A. Before a person can receive Supported Employment services, he/she must first be referred by his/her Support Coordinator to the Department of Rehabilitation Services to determine his/her eligibility for services from that agency. Documentation must be maintained in the record of each individual receiving Supported Employment Services that verifies the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

B. Supported Employment is the ongoing support to individuals who, because of their disabilities, will need intensive, ongoing support to obtain and maintain an individual job in competitive or self-employment.

C. Employment must be in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

D. Providers must work to reduce the number of hours of staff involvement as the employee becomes more productive and less dependent on paid supports. This is decided on an individual basis based on the job and task analysis shared with all staff involved as well as the employer, amount of support recommended by the employer, the Department of Rehabilitation Services and the person's team.

E. Supported Employment Services are provided in a work site where individuals without disabilities are employed; therefore, payment is made only for adaptations, supervision, and training required by individuals receiving waiver services as a result of their

disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

F. Other workplace supports may include services not specifically related to job skills training that enable the individual to be successful in integrating into the job setting.

G. Each individual must have an Activity Support Plan that is developed based on his/her Plan of Services and Supports.

H. Providers must be able to provide all activities that constitute Supported Employment:

1. Job Seeking – Activities that assist and individual in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Seeking is limited to ninety (90) hours. Additional hours may be needed if a person needs to find another job. Job seeking includes:
   (a) Completion of IDD Employment Profile
   (b) Person Centered Career Planning which is a discussion of specific strategies that will be helpful to assist job seekers with disabilities to plan for job searches
   (c) Job Development
      (1) What environment does the person enjoy
      (2) In what environments has the person experienced success
      (3) What work and social skills does the person bring to the environment
      (4) What environments are their skills viewed as an asset
      (5) What types of work environments should be avoided
   (d) Employer research
   (e) Employer needs assessment
      (1) Tour the employment site to capture the requirements of the job
      (2) Observe current employees
      (3) Assess the culture and the potential for natural supports
      (4) Determine unmet needs
   (f) Negotiation with prospective employers
      (1) Employer needs are identified
      (2) Job developer acts as a representative for the job seeker

2. Job Coaching – Activities that assist and individual to learn and maintain a job in the community. The amount of Job Coaching a person receives is dependent upon individual need, team recommendations, and employer evaluation. Job coaching includes:
   (a) Meeting and getting to know co-workers and supervisors
   (b) Learning company policies, dress codes, orientation procedures, and company culture
   (c) Job and task analysis
      (1) Core work tasks
      (2) Episodic work tasks
      (3) Job related tasks
      (4) Physical demands

(5) Sensory and communication demands
(6) Academic demands

(d) Systematic instruction
    (1) Identification and instructional analysis of the goal
    (2) Analysis of entry behavior and learner characteristics
    (3) Performance Objectives
    (4) Instructional strategy

(e) Identification of natural supports
    (1) Personal associations and relationships typically developed in the community that enhance the quality and security of life
    (2) Focus on natural cues
    (3) Establish circles of support

(f) Ongoing support and monitoring

I. If an individual moves from one job to another or advances within the current employment site, it is the Supported Employment provider's responsibility to update the profile/resume created during the job search

J. Transportation will be provided between the individual's place of residence for job seeking as well as between the site of the individual's job or between habilitation sites as a component part of Supported Employment. Transportation cannot comprise the entirety of the service. If local or other transportation is available, the individual may choose to use it but the provider is ultimately responsible for ensuring the availability of transportation.

K. Supported Employment may also include services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based. Such assistance may include:

1. Assisting the individual to identify potential business opportunities
2. Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and starting a business (e.g. internet and telephone service, website development, advertising, incorporation, taxes, etc.).
3. Identification of the supports that are necessary for the individual to operate the business
4. Ongoing assistance, counseling and guidance once the business has been launched.
5. Up to fifty-two (52) hours per month of at home assistance by a job coach, including business plan development and assistance with tasks related to producing the product
6. Up to thirty-five (35) hours per month for assistance in the community by a job coach.

L. Payment is not made for any expenses associated with starting up or operating a business. Referrals for assistance in obtaining supplies and equipment for someone desiring to achieve self-employment should be developed with the Mississippi Department of

Rehabilitation Services. There must be documentation of the referral in the person's record.

M. Assistance with toileting and hygiene may be a component part of Supported Employment, but may not comprise the entirety of the service.

N. Individuals cannot receive Supported Employment and Job Discovery.

O. Supported Employment does not include facility based or other types of services furnished in a specialized facility that are not part of the general workforce. Supported Employment cannot take place in a facility based program.

P. Supported Employment does not include volunteer work, career exploration or internships.

Q. Providers are prohibited from making incentive payments to an employer to encourage or subsidize the employer's participation in the Supported Employment Program and/or passing payments through to users of Supported Employment Services.

R. Individuals receiving Supported Employment may also receive Prevocational Services or Day Services-Adult services, but not at the same time of day.

S. An individual must be at least 18 years of age to participate in Supported Employment and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

T. All required staff and/or those chosen by the person, must participate in the development of the Plan of Services and Supports.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 27.6 Work Activity Services

A. Work Activity Services for persons with intellectual disabilities/developmental disabilities provide opportunities for the acquisition of necessary work and living skills. A person must be at least sixteen (16) years old to participate in Work Activity Services. (Accepting individuals younger than eighteen (18) is optional for the provider.)

B. Each program must be certified by the U.S. Department of Labor. The appropriate Department of Labor certificate must be posted in a public area at each Work Activity service site.

C. Work Activity Services must include:

1. Work which is:

(a) Real, remunerative, productive, and satisfying for the individual served; and
(b) Planned and adequate to keep all individuals productively and appropriately occupied.

2. Non-work which:
   (a) Is intended to increase and enhance activities which allow the individual to be more self-sufficient and to increase community employment and integration;
   (b) Takes place when work is reduced and/or when the individual chooses.

D. The Plan Services and Supports for all participants in Work Activity Services must include a career development outcome that addresses an individual's desire for integrated community employment and activities to support the individual in the achievement of that outcome.

E. The program must have adequate work to keep individuals productively occupied while at the center.

F. The program must assure reasonable accommodations in assisting the individual in increasing his/her productivity. Expected accommodations must, as needed, include:

1. Modifying equipment, jigs, and fixtures.
2. Modifying the work site and commonly used surrounding areas.
3. Purchasing aids and devices to assist individuals with their work.
4. Allowing flex time, part-time or extended break time.

G. Wage payments must be monetary and not in-kind or barter. Records pertaining to individual wages must include, at a minimum, the following:

1. Individual's name
2. Hours worked
3. Task(s) performed
4. Wages paid
5. Method of payment (cash, check, direct deposit.).

H. Each person must receive a written statement for each pay period which must include:

1. Gross pay
2. Net pay
3. Hours worked
4. Deductions
5. The individual's signature indicating he/she received a written statement (even if individual has chosen the option of direct deposit). These signatures must be maintained in the individual's record.

I. Pay periods cannot exceed thirty-one (31) calendar days.

J. The program must complete Time Studies and maintain the documentation in order to demonstrate wage payments are based on a system of individual performance rather than pooled and/or group wage payments.

K. Community wage rate information must be obtained annually and must include at a minimum the following:

1. Prevailing wage for the type or similar type of work being performed;
2. Dates community wage rate information was obtained; and
3. Source of the information.

L. Work Activity center staff must meet at least annually with the individuals to discuss matters of mutual concern. The program must maintain minutes for the meeting and ensure at least the following are addressed:

1. Individuals are informed of any aspects of program operations and plans which effect their wages or welfare;
2. Individuals are asked for suggestions for changes/improvements they would like to see; and
3. Individuals are afforded the opportunity to ask questions and receive answers.

M. A minimum of fifty (50) square feet of usable space per individual receiving services must be maintained in the work area. The program must have adequate floor space for a lounge/break/dining area separate from the work area.

N. Preventive measures must be utilized at all times to ensure the safety of the individuals and staff which include, at a minimum:

1. The safe use of equipment.
2. The use of protective clothing, shoes, and eyewear.
3. The proper storage of flammable liquids or other harmful materials in approved containers. If the liquids/harmful materials are not in their original container, it must be clearly marked to identify its contents.
4. The storage and control of raw materials and finished products outside the work area.
5. The replacement of worn electrical cords or machinery; and
6. The maintenance of the site and equipment in a safe manner.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 27.7 Day Habilitation for IDD Community Support Program</u>

A. Day Habilitation is the provision of regularly scheduled, individualized activities in a non-residential setting, separate from the participant's private residence or other residential living arrangements Group and individual participation in activities that include daily living and other skills that enhance community participation and

meaningful days for each individual are provided. Personal choice of activities as well as food, community participation, etc. is required and must be documented on the designated form and be maintained in each person's record.

B. Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice. Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices including what he/she does during the day and with whom they interact.

C. Day Habilitation must have a community component that is individualized and based upon the choices of each person. Community participation activities must be offered to the same degree of access as someone not receiving IDD Community Support Program services. Community integration can be provided individually or in groups of up to three (3) people. Community participation activities may be received at the same time with individuals receiving Day Services Adult but not with individuals receiving any other service.

D. Community integration opportunities must be offered to each individual at least weekly and address at least one of the following:

   1. Activities which address daily living skills
   2. Activities which address leisure/social/other community activities and events.

E. Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.

F. Transportation is not required to be provided to and from the program but must be provided for community outings.

G. Day Habilitation includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day.

H. A private changing/dressing area must be provided to ensure the dignity of each individual.

I. All supplies and equipment must be appropriate for adults, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired.

J. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events, both at the certified site and in the community.

K. Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports.

L. Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.

M. The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be offered choices about what they eat and drink.

N. Each individual must have an Activity Support Plan that is developed based on his/her Plan of Services and Supports.

O. Individuals receiving Day Habilitation may also receive Prevocational services but not on the same day. Individuals receiving Day Habilitation may also receive Supported Employment but not at the same time of day.

P. The program must be in operation at least five (5) days per week, six (6) hours per day. The number of hours of service is based on the individual's approved Plan of Services and Supports and cannot be delivered less than four (4) hours per day one (1) day per week.

Q. There must be a minimum of fifty (50) square feet of usable space per every person in the program. Additional square footage may be required based on the needs of an individual.

R. Day Habilitation activities must be distinct from Day Services Adult activities.

S. Staffing ratio for persons in Day Habilitation is one (1) staff for every eight (8) persons. If individuals receiving Day Services-Adult are served alongside individuals receiving Day Habilitation, the staffing ratios for both must be maintained.

T. Individuals must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

U. Day Habilitation does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

V. The program must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving ID/DD Community Support Program services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 28: Community Living Services for Individuals with SMI

Rule 28.1 Supervised Living for SMI Service Components

A. Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance,

B. Supervised Living Services may be intensive, time-limited for adults with serious mental illness in order to provide readjustment and transitional living services for individuals discharged from a psychiatric hospital who have demonstrated mental, physical, social and emotional competency to function more independently in the community. These time-limited services may also be provided for individuals who need this service as an alternative to a more restrictive treatment setting.

C. Supervised Living Services must include the following services as appropriate to each individual's support needs:

1. Direct personal care assistance activities such as:

   (a) Grooming
   (b) Eating
   (c) Bathing
   (d) Dressing
   (e) Personal hygiene

2. Instrumental activities of daily living which include:

   (a) Assistance with planning and preparing meals
   (b) Cleaning
   (c) Transportation
   (d) Assistance with ambulation and mobility
   (e) Supervision of the individual's safety and security
   (f) Banking
   (g) Shopping
   (h) Budgeting
   (i) Facilitation of the individual's participation in community activities
   (j) Use of natural supports and typical community services available to everyone
   (k) Social activities
   (l) Participation in leisure activities
   (m) Development of socially valued behaviors

(n) Assistance with scheduling and attending appointments

3. Methods for assisting individuals arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Documentation of the following must be maintained in each person's record:

   (a) Assistance with making doctor/dentist/optical appointments;
   (b) Transporting and accompanying individuals to such appointments; and
   (c) Conversations with the medical professional, if the individual gives consent.

4. Transporting individuals to and from community activities, other places of the individual's choice (within the provider's approved geographic region), work, and other sites as documented in the individual plan.

5. If Supervised Living staff members have been unable to participate in the development of the individual's plan, staff must be trained regarding the individual's plan prior to beginning work with the individual. This training must be documented.

6. Orientation of the individual to Community Living Services, to include but not limited to:

   (a) Familiarization of the individual with the living arrangement and neighborhood;
   (b) Introduction to support staff and other residents (if appropriate)
   (c) Description of the written materials provided upon admission and
   (d) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.

D. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided throughout the day. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.

   1. Individuals must have access to food at any time, unless prohibited by his/her individual plan.
   2. Individuals must have choices of the food they eat.
   3. Individuals must have choices about when and with whom they eat

E. Individuals receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as part of the Supervised Living program.

F. In living arrangements in which the residents pay rent and/or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:

1. Procedures for setting and collecting fees and/or room and board (in accordance with Part 2: Chapter 10 Fiscal Management)
2. A detailed description of the basic charges agreed upon (e.g. rent (if applicable), utilities, food, etc.)
3. The time period covered by each charge (must be reviewed at least annually or at any time charges change)
4. The service(s) for which special charge(s) are made (e.g., internet, cable, etc.)
5. The written financial agreement must be explained to and reviewed with the individual/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.
6. A requirement that the individual's record contain a copy of the written financial agreement which is signed and dated by the individual/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. A signed copy must also be given to the individual/legal guardian.
7. The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to prevent the individual from becoming homeless as a result of discharge/termination from the community living services.

G. Individuals must be 18 years or older to participate in Supervised Living.

H. A qualified staff member must be designated as responsible for the program site at all times. There must be male/female staff coverage when as necessary.

I. Apartment settings with an apartment manager with responsibilities related to collection of fees, maintenance, etc., must also have at least one treatment/support staff on site in order to be considered Supervised Living.

J. There must be at least one staff person physically on-site when individuals are present.

K. A maximum of eight (8) individuals may reside in a single residence for programs initially certified after the effective date of these standards.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 28.2 Environment and Safety for Supervised Living for SMI

A. Supervised Living sites must, to the maximum extent possible, duplicate a "home-like" environment.

B. All sites must have furnishings that are safe, up-to- date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent possible, are chosen by the individuals currently living in the home.

C. All providers must provide access to a washer and dryer in the home, apartment, or apartment complex and must ensure the laundry room or area has an exterior ventilation system for the clothes dryer.

D. Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

E. Resident bedrooms must not have windows over forty-four inches off the floor if identified as a means of egress. All windows at all levels must be operable.

F. Resident bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

G. Resident bedrooms must be appropriately furnished with a minimum of a single bed, chest of drawers, appropriate lighting and adequate storage/closet space for each resident;

H. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances.

I. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used.

J. Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

K. Individuals have the freedom to furnish and decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, etc.

L. All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

M. All programs must ensure bathtubs and showers are equipped with:

1. Soap dishes;

2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

N. Each resident must be provided at least 2 sets of bath linens, including bath towels, hand towels, and wash cloths.

O. All Supervised Living sites of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system.

P. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas.

Q. Residential facilities using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas.

R. Each bedroom must have at least two means of escape.

S. The exit door(s) nearest the residents' bedrooms must not be locked in a manner that prohibits ease of exit.

T. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom.

U. All providers must ensure visiting areas are provided for residents and visitors and each visiting area must have at least two (2) means of escape.

V. All sites must have separate storage areas for:

1. Sanitary linen;
2. Food (Food supplies cannot be stored on the floor.); and
3. Cleaning supplies.

W. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

X. The setting is integrated in and supports full access to the community to the same extent as people not receiving Supervised Living services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 28.3 Supported Living for SMI Service Components

A. Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Supported Living services are provided in a homelike setting where people have access to the community at large to the same extent as people who do not have a serious mental illness.

B. Supported Living Services are for individuals age 18 and above with serious mental illness and are provided in residences in the community for six (6) or fewer individuals.

C. Supported Living provides assistance with the following, depending on each individual's support needs:

   1. Grooming
   2. Eating
   3. Bathing
   4. Dressing
   5. Personal hygiene.

D. Supported Living provides assistance with instrumental activities of daily living which include assistance with:

   1. Planning and preparing meals
   2. Transportation or assistance with securing transportation
   3. Assistance with ambulation and mobility
   4. Supervision of the individual's safety and security
   5. Banking
   6. Shopping
   7. Budgeting
   8. Facilitation of the individual's inclusion participation in community activities
   9. Use of natural supports and typical community services available to all people in order to facilitate meaningful days.

E. Providers must develop methods, procedures and activities to provide meaningful days and independent living choices about activities/services/staff for the individual(s) served in the community.

F. Procedures must be in place for individual(s) to access any other needed services as well as typical community services available to all people in order to facilitate meaningful days and development of natural supports.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 28.4 Supported Living Services for SMI Environment and Safety

A. Each housing unit/house must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the home , (i.e., kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

B. Providers must document that all fire extinguishers are properly maintained and serviced. Homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

C. Each housing unit/house must have, at a minimum, operable carbon monoxide detector where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

D. In lieu of posted escape routes, providers must document training that prepares an individual to exit their housing unit/house in the event of emergency.

E. At least annually, training must be provided to adults individuals receiving Supported Living Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following:

    1. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;
    2. Fire, smoke and carbon monoxide safety and the use of detectors. If necessary, staff must assist in obtaining and mounting fire, smoke and carbon monoxide detectors;
    3. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature, documenting such in a log to be maintained by the provider staff; and,
    4. Any other health/safety issues based on the needs or identified risk for each individual.

F. All training for Supported Living must take place upon admission and at least annually thereafter. Documentation is to be maintained in the person's record.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 29: Community Living Services for Children and Youth with SED

Rule 29.1 All Community Living Services for Children/Youth with SED

A. Each child/youth (ages 5 to 16 years) must be enrolled and attend in an appropriate educational program in the local school district or be enrolled in an educational program operated by the provider that meets the individualized educational needs of the child/youth and is accredited by the Mississippi Department of Education. The Community Living Handbook must describe how this occurs for the children/youth served.

B. Providers must provide a balance of age-appropriate, goal-oriented activities to meet the individualized needs and build on the strengths of the children/youth served in the program. Areas to be addressed by such programs must include the following:

   1. Social skills development based on each child's diagnosis and functional assessment
   2. Wellness education
   3. Increasing self-esteem
   4. Leisure activities
   5. Substance abuse education/counseling
   6. HIV/AIDS education and/or counseling
   7. Education and counseling about sexually transmitted diseases.

C. Providers must describe how group and individual activities, as well as routines for the children and youth are planned and how these activities are related to objectives in the Individual Service Plans of children and youth served in the program. Daily and weekly schedule(s) of activities must be maintained on file for at least three (3) months.

D. Providers must obtain written permission from the parent or legal representative for the child/youth to participate in program activities away from the Supervised Living location.

E. Providers must ensure child/youth has a dental examination within sixty (60) days after admission and annually thereafter or have evidence of a dental examination within 12 months prior to admission to the Supervised Living program.

F. Providers must place a current, dated photograph of the child in his/her record within thirty (30) days of admission.

G. Providers of services to children/youth under the age of eighteen (18) must have on file an assurance signed by the Executive Director of the Supported Living Service provider stating compliance with the provisions of Public Law 103-227 (Pro-Children Act of 1994). Note: Providers funded by the DMH must have a current "Certification Regarding Environmental Tobacco Smoke."

H. All environmental and physical safety requirements for foster homes and therapeutic group homes are under the jurisdiction of the MS Department of Human Services. DMH is responsible for certifying and monitoring the therapeutic/clinical components of therapeutic foster care services and therapeutic group home services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 29.2 Therapeutic Foster Care for Children/Youth with SED

A. Providers of Therapeutic Foster Care (TFC) must also meet the requirements in Rule 29.1.

B. Therapeutic Foster Care (TFC) services are intensive community-based services for children with significant developmental, emotional or behavioral needs provided by mental health professional staff and trained foster parents, resource parents or group home providers who provide a therapeutic program for children and youth with serious emotional disturbances living in a resource home licensed by the Department of Human Services. All environmental and physical safety requirements for therapeutic foster homes are under the jurisdiction of the regulations of the MS Department of Human Services. DMH is not responsible for the licensing or monitoring of therapeutic foster homes. DMH is responsible for the certification of the therapeutic services provided.

C. TFC providers can use only adults with current documentation of foster parent or resource family approval from the Mississippi Department of Human Services.

D. Each foster home or resource home must have no more than one (1) child/youth with serious emotional disturbance placed in the home at a given time. Providers seeking to place more than one (1) child/youth with serious emotional disturbance in a resource home must obtain prior approval from the Mississippi Department of Human Services. Siblings with serious emotional disturbance may be placed together in the same home if all of the following conditions apply:

   1. The siblings have never been separated;
   2. The siblings are not a danger to others; and
   3. Therapeutic resource parents asked to place siblings in their home must consent, in advance in writing, to the placement. This documentation must be maintained in the individual record of each sibling.

E. Each TFC provider licensed for a minimum of ten (10) foster homes or resource homes must have a full-time director with overall administrative and supervisory responsibility for the services.

   1. If the TFC provider is certified for fewer than ten (10) homes, the director can have administrative or supervisory responsibility for other services or programs; however,

documentation must be maintained that at least fifty percent (50%) of the director's time is spent in administration and supervision of the TFC services.

F. Each TFC provider licensed for ten (10) to thirty (30) foster homes or resource homes must have one full-time Treatment Foster Care specialist whose services target the therapeutic foster parents or resource families. The TFC specialist's specific responsibilities must include at least the following:

1. Recruitment and training of therapeutic foster parents or therapeutic resource parents
2. Conducting interviews and other necessary work to appropriately place individual children and youth with prospective therapeutic foster care or resource parents
3. Maintenance of regular contacts with therapeutic foster care or resource families and provide documentation of those contacts in the case records
4. Performance of other foster parent or resource family support activities, as needed.

G. If the TFC provider is licensed for fewer than ten (10) foster or resource homes, the TFC specialist can have other responsibilities; however, documentation must be maintained that at least ten percent (10%) of his/her time for every one (1) therapeutic foster home or resource home is spent in performing duties of the TFC specialist/community support specialist.

H. The TFC specialist must have face-to-face contact with each therapeutic foster or resource parent(s) at least two (2) times per month, with at least one (1) of the two (2) contacts made during a home visit. All contacts of the TFC specialist with the therapeutic foster or resource parent(s) must be documented in the individual case record of the therapeutic resource parent(s).

I. All clinical/mental health therapeutic services for all children receiving TFC services must be provided by a staff member who holds a Master's degree and professional license or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving services and the service being provided).

J. TFC Services must include individual therapy, family therapy, annual psychiatric evaluation, and twenty-four (24) hour per day and seven (7) days a week emergency services and crisis intervention. Group therapy may also be provided.

K. Each TFC provider must have one (1) full-time professionally licensed or DMH credentialed mental health therapist for every twenty (20) foster children/youth in the TFC program. The mental health therapist(s) for the TFC services must serve only in the mental health therapist role (i.e. cannot serve as the director or the TFC specialist).

L. The mental health therapist is required to have at least one individual therapy session per week with the child/youth. At least one family session per month is required with the resource parent(s).

M. A licensed psychiatrist with experience working with children/youth, on an employment or contractual basis, must be available for youth served by the TFC provider.

N. All resource parents must complete annual training as required in Part 2: Chapter 12. Topics should be addressed from a family perspective.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 29.3 Therapeutic Group Homes for Children and Youth with SED

A. Providers of Therapeutic Group Homes (TGH) must also meet the requirements in Rule 29.1.

B. The maximum bed capacity of each TGH is ten (10) beds per home for children and youth twelve (12) years of age through age twenty (20) years and (11) eleven months and eight (8) beds for children and youth ages six (6) years through eleven (11) years and eleven (11) months. The Mississippi DMH may require a lower bed capacity than described in this standard, depending on the age, developmental or level of functioning, or intensity of need for intervention and supervision of the population of children and youth served in the individual home.

C. There may not be more than two (2) children/youth per bedroom in a Therapeutic Group Home.

D. The provider must ensure that the staff on-site is of a sufficient number to provide adequate supervision of child/youth in a safe, therapeutic home environment and must meet the following minimum requirements:

1. In TGH's with five (5) or fewer children or youth, at least one (1) staff member (which can be a direct care worker or house parent) with a least a Bachelor's degree in a mental health or related field must be assigned to direct service responsibilities for the children/youth during all hours.
2. For TGH's with six (6) to ten (10) children or youth, at least two (2) staff must be assigned to direct service responsibilities during all hours children or youth are awake and not in school. One (1) of the two (2) staff can be a direct care worker or house parent and one must be a professional staff member with at least a Bachelor's degree in a mental health or related field.
3. Have a full-time director who is on-site at least forty (40) hours per week.
4. Other appropriate professional staff must be available to assist in emergencies, at least on an on-call basis, at all times.
5. DMH may require a staff to youth ratio lower than described above, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of children or youth served by the individual home.

E. A licensed psychiatrist and a professionally licensed or DMH credentialed mental health

therapist with experience working with children/youth must be available for children/youth served by the TGH.

F. Programs must provide each child/youth with therapeutic activities and experience in the skills they need to support a successful transition to a less restrictive setting or level of service.

G. The mental health therapist is required to have at least one individual therapy session per week with the child/youth.

H. Transition plans must be developed within ninety (90) days prior to completion of a TGH program and be included in the child/youth's record and shared with community service providers.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 29.4 Community Living Handbook

A. In addition to information contained in the provider's policy and procedure manual, Therapeutic Group Home providers must develop a Handbook which includes all policies and procedures for provision of TGH Services. Handbooks are to be provided to the individual/parent/legal representative during orientation. The Community Living Handbook must be readily available for review by staff and must be updated as needed.

B. All providers of TGH Services must document that each individual (and/or parent/guardian) is provided with a handbook and orientation on the day of admission. The provider must document the review of the handbook with the resident annually (if applicable to the service).

C. All TGH providers must have a written plan for soliciting input from residents about all sections of the handbook.

D. The service and site-specific handbook must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative.

E. TGH providers must have a written plan for providing the handbook information in a resident's language of choice when necessary if English is not their primary language.

F. The Community Living handbook may not be a book of rules.

G. The Handbook may not include any rules or restrictions that infringe on or limit the individual's ability to live in the least restricted environment possible or that limit oc restrict the rights of individuals receiving services specified in Chapter 14 of these standards.

H. At a minimum, the Community Living Handbook must address the following:

1. A person friendly, person first definition and description of the community living service being provided;
2. The philosophy, purpose and overall goals of the service, to include but are not limited to:

   (a) Methods for accomplishing stated goals and objectives
   (b) Expected results/outcomes
   (c) Methods to evaluate expected results/outcomes.

3. Description of the service components, including the minimum levels of staffing required for the safety and guidance of individuals to be served
4. A description of how the TGH service addresses the following items, to include but not limited to:

   (a) Visitation guidelines (applying to family, significant others, friends and other visitors) that are appropriate to TGH services
      (1) Individual's right to define their family and support systems for visitation purposes unless clinically/socially contraindicated
      (2) All actions regarding visitors (restrictions, defining individual and family support systems, etc.) must be documented in the individual's case record
      (3) Any restrictions on visitors must be reviewed whenever there is an identified need or request by the individual to change any of the restrictions
      (4) Visitation rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.
      (5) To the greatest extent possible, individuals should have visitors of their choosing at any time.

   (b) Daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated:
      (1) Any restrictions on private telephone use must be reviewed daily
      (2) All actions regarding restrictions on outside communication must be documented in the case record
      (3) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.

   (c) Dating
   (d) Off-site activities
   (e) Household tasks
   (f) Curfew
   (g) Respecting the rights of other residents' privacy, safety, health and choices.

5. Policy regarding the search of the individual's room, person and/or possessions, to include but not limited to;

(a) Circumstances in which a search may occur;
(b) Staff designated to authorize searches;
(c) Documentation of searches; and
(d) Consequences of discovery of prohibited items.

6. Policy regarding screening for prohibited/illegal substances, to include but not limited to:

(a) Circumstances in which screens may occur;
(b) Staff designated to authorize screening;
(c) Documentation of screening;
(d) Consequences of positive screening of prohibited substances;
(e) Consequences of refusing to submit to a screening; and
(f) Process for individuals to confidentially report the use of prohibited substances prior to being screened.

7. Orientation of the individual to TGH Services, to include but not limited to:

(a) Familiarization of the individual with the living arrangement and neighborhood;
(b) Introduction to support staff and other residents (if appropriate)
(c) Description of the written materials provided upon admission (i.e., handbook, etc.); and
(d) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.

8. Methods for assisting individuals in arranging and accessing routine and emergency medical and dental care, to include but not limited to:

(a) Agreements with local physicians and dentists to provide routine care
(b) Agreements with local physicians, hospitals and dentists to provide emergency care
(c) Process for gaining permission from parent/guardian, if necessary.

I. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights;

J. Determination of the need for and development, implementation and supervision of behavior change/management programs;

K. Description of how risks to health and safety of individuals in the program are assessed and the mitigation strategies put in place as a result of assessment; and,

L. Criteria for termination\discharge from the TGH Service.

M. Providers must also address:

1. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared. Individuals must have access to food at any time, unless prohibited by his/her individual plan
2. Personal hygiene care and grooming, including any assistance that might be needed;
3. Medication management (including storing and dispensing); and,
4. Prevention of and protection from infection, including communicable diseases.

N. Providers must develop policies regarding pets and animals on the premises for all TGH programs.

O. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 30: Supervised Living for Individuals with IDD

Rule 30.1 Supervised Living Services for IDD Service Components

A. Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance,

B. Supervised Living Services must include the following services as appropriate to each individual's support needs:

1. Direct personal care assistance activities such as:

   (a) Grooming
   (b) Eating
   (c) Bathing
   (d) Dressing
   (e) Personal hygiene

2. Instrumental activities of daily living which include:

   (a) Assistance with planning and preparing meals
   (b) Cleaning
   (c) Transportation
   (d) Assistance with ambulation and mobility
   (e) Supervision of the individual's safety and security
   (f) Banking
   (g) Shopping
   (h) Budgeting
   (i) Facilitation of the individual's participation in community activities
   (j) Use of natural supports and typical community services available to everyone
   (k) Social activities
   (l) Participation in leisure activities
   (m) Development of socially valued behaviors
   (n) Assistance with scheduling and attending appointments

3. Methods for assisting individuals arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Documentation of the following must be maintained in each person's record:

   (a) Assistance with making doctor/dentist/optical appointments;

(b) Transporting and accompanying individuals to such appointments; and
(c) Conversations with the medical professional, if the individual gives consent.

4. Transporting individuals to and from community activities, other places of the individual's choice (within the provider's approved geographic region), work, and other sites as documented in the individual plan.

5. If Supervised Living staff members have been unable to participate in the development of the individual's plan, staff must be trained regarding the individual's plan prior to beginning work with the individual. This training must be documented.

6. Orientation of the individual to Community Living Services, to include but not limited to:

   (a) Familiarization of the individual with the living arrangement and neighborhood;
   (b) Introduction to support staff and other residents (if appropriate)
   (c) Description of the written materials provided upon admission and
   (d) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.

C. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided throughout the day. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.

   1. Individuals must have access to food at any time, unless prohibited by his/her individual plan.
   2. Individuals must have choices of the food they eat.
   3. Individuals must have choices about when and with whom they eat

D. Individuals receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as part of the Supervised Living program.

E. In living arrangements in which the residents pay rent and/or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:

   1. Procedures for setting and collecting fees and/or room and board (in accordance with Part 2: Chapter 10 Fiscal Management)
   2. A detailed description of the basic charges agreed upon (e.g. rent (if applicable), utilities, food, etc.)
   3. The time period covered by each charge (must be reviewed at least annually or at any time charges change)
   4. The service(s) for which special charge(s) are made (e.g., internet, cable, etc.)

5. The written financial agreement must be explained to and reviewed with the individual/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.
6. A requirement that the individual's record contain a copy of the written financial agreement which is signed and dated by the individual/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. A signed copy must also be given to the individual/legal guardian.
7. The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to prevent the individual from becoming homeless as a result of discharge/termination from the community living services.
8. Individuals receiving ID/DD Waiver services must be afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to125 and §89-8-1 to 89-8-1 to 89).

F. Individuals must be 18 years or older to participate in Supervised Living.

G. There must be at least one staff person in the same dwelling as people receiving services at all times that is able to respond immediately to the requests/needs for assistance from the individuals in the dwelling. Staff must be awake at all times.

H. Sites certified after the effective date of the standards, can have no more than four (4) people residing in the home.

I. Individuals have freedom and support to control their own schedules and activities.

1. Individuals cannot be made to attend a day program if they choose to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if they are ill, or otherwise choose to remain at home.
2. Staff must be available to support individual choice.

J. For ID/DD Waiver Supervised Living, there must be a Supervised Living Program Supervisor for a maximum of four (4) Supervised Living locations. The Supervised Living Program Supervisor must meet the qualifications in Standard 11.3.D. Waiver Supervised Living Program Supervisors may be limited to supervise less than 4 homes if deemed necessary by DMH.

1. The Supervised Living Program Supervisor is responsible for providing weekly supervision and monitoring at all four (4) sites.
2. Unannounced visits on all shifts, on a rotating basis must take place monthly.
3. All supervision activities must be documented and available for DMH review. Supervision activities include but are not limited to: review of daily Service Notes to determine if outcomes identified on a person's Plan of Services and Supports are being met; review of meals, meal plans and food availability; review of purchasing; review of individuals' finances and budgeting; review of each individual's

satisfaction with services, staff, environment, etc.

K. Individuals must have control over their personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.

L. Nursing services are a component of ID/DD Waiver Supervised Living services and must be provided in accordance with the MS Nursing Practice Act. Nursing services are a component part of ID/DD Waiver Supervised Living. They must be provided on an as-needed basis. Only activities within the scope of the Nurse Practice Act and Regulations can be provided. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring, etc.

M. Staffing levels are based on the ratios set by a person's score on his/her ICAP.

N. A higher reimbursement rate may be available for individuals enrolled in the ID/DD Waiver who are considered medically fragile and whose medical condition requires intensive supports, including skilled nursing services, that exceed what is required in Rule 30.1.K. Admission must be prior approved by BIDD. Individuals living in the home with someone considered medically fragile must be compatible and not pose a threat to the person who has higher medical support needs.

O. A higher reimbursement rate may be available for individuals enrolled in the ID/DD Waiver who have documented patterns of violent and/or non-violent behavior that pose a risk to themselves or others and who require intensive supports in order to live in the community. This may include one-to-one staff ratios and/or line of sight supervision. Admission must be prior approved by BIDD. Individuals living in the home with someone who requires higher levels of behavior support must be compatible. The person receiving a higher level of support must not pose a threat to others living in the home.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 30.2 Environment and Safety for Supervised Living for IDD

A. Supervised Living sites must, to the maximum extent possible, duplicate a "home-like" environment.

B. All sites must have furnishings that are safe, up-to- date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent possible, are chosen by the individuals currently living in the home.

C. All providers must provide access to a washer and dryer in the home, apartment, or apartment complex and must ensure the laundry room or area has an exterior ventilation system for the clothes dryer.

D. Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

E. Resident bedrooms must not have windows over forty-four inches off the floor if identified as a means of egress. All windows at all levels must be operable.

F. Resident bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

G. Resident bedrooms must be appropriately furnished with a minimum of a single bed, chest of drawers, appropriate lighting and adequate storage/closet space for each resident;

H. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances.

I. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used.

J. Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

K. Individuals have the freedom to furnish and decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, etc.

L. All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

M. All programs must ensure bathtubs and showers are equipped with:

1. Soap dishes;

2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

N. Each resident must be provided at least 2 sets of bath linens, including bath towels, hand towels, and wash cloths.

O. All Supervised Living sites of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system.

P. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas.

Q. Residential programs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas.

R. Each bedroom must have at least two means of escape.

S. The exit door(s) nearest the residents' bedrooms must not be locked in a manner that prohibits ease of exit.

T. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom.

U. All providers must ensure visiting areas are provided for residents and visitors and each visiting area must have at least two (2) means of escape.

V. All sites must have separate storage areas for:

1. Sanitary linen;
2. Food (Food supplies cannot be stored on the floor.); and
3. Cleaning supplies.

W. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

X. The setting is integrated in and supports full access to the community to the same extent as people not receiving Supervised Living services.

Y. There must be visiting hours that are mutually agreed upon by all people living in the residence. Visiting hours cannot be restricted unless mutually agreed upon by all people living in the dwelling.

Z. Providers must provide furnishings used in common areas (den, dining, and bathrooms) if:

1. The individual does not have these items; or
2. These items are not provided through Bridge to Independence (Money Follows the Person) or Transition Assistance through the ID/DD waiver.

AA. Individuals have choices about housemates and with whom they share a room. There must be documentation in each person's record of the person/people they chose to be their roommate.

BB. Individuals must have keys to their living unit if they so choose.

CC. The setting is selected by the individual from setting options including non-disability specific settings and the option of having a private unit, to the degree allowed by personal finances, in the residential setting. This must be documented in the record.

DD. Bedrooms must have lockable entrances with each person having a key to his/her bedroom and only appropriate staff having keys.

EE. Individuals share bedrooms based on their choices. No more than two individuals may share a bedroom. If a person must share a bedroom, it must be prior approval from BIDD.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 30.3 ID/DD Waiver Host Homes

A. Host Homes must also meet the requirements in Rule 30.1.

B. Host Homes are private homes where no more than one individual who is at least five (5) years of age lives with a family and receives personal care and supportive services. If the person requesting this service is under five (5) years of age, admission must be prior approved by the BIDD Director.

C. Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment.

D. Host Home services include assistance with personal care, leisure activities, social development, family inclusion, community inclusion, and access to medical services. Natural supports are encouraged and supported. Supports are to be consistent with the participant's skill level, goals, and interests.

E. Host Homes are administered and managed by provider agencies that are responsible for all aspects of Host Home Services. Host Home agencies must:

1. Complete an evaluation of each prospective Host Home family and setting. The evaluation must be prior approved by BIDD;
2. Conduct background checks for all Host Home family members over the age of 18;
3. Provide training to Host Home providers that is in compliance with Chapter 12;
4. Ensure each Host Home family member has had a medical examination within twelve (12) months of anyone moving into the Host Home and at least annually thereafter;
5. Maintain current financial and property records for each individual served in a Host Home;
6. Conduct at least monthly home visits to each Host Home;
7. Ensure availability, quality and continuity of Host Homes;
8. Take into account compatibility with the Host Home Family member(s) including age, support needs, and privacy needs;
9. Ensure each individual receiving Host Home services has his/her own bedroom;
10. Recruit and oversee the Host Home
11. Have 24-hour responsibility for the Host Homes which includes back-up staffing for scheduled and unscheduled absences of the Host Home family.
12. Have plans for when a Host Home family becomes unable to provide the services to someone on an immediate basis. The agency must ensure the availability of back-up plans to support the person until another suitable living arrangement can be secured.

F. Relief staffing may be provided in the individual's Host Home by another certified Host Home Family or by staff of the Host Home agency or in another Host Home Family's home.

G. Host Home Family components:

1. The principal caregiver in the Host Home must attend and participate in the meeting to develop the individual's Plan of Services and Supports (PSS).
2. The Host Home Family must follow all aspects of the individual's PSS and any support/activity plan (e.g. Plan of Services and Supports, Behavior Support Plan, nutrition plan, etc.) the individual might have.
3. The Host Home Family must take and assist the individual in attending appointments (i.e., medical, therapy, etc.).
4. The Host Home Family must provide transportation as would a natural family member.
5. The principal caregiver must maintain required documentation.
6. The Host Home Family must meet all staff training requirements as outlined in the DMH Operational Standards.
7. The Host Home Family and/or principal caregiver must participate in all training provided by the Host Home agency.
8. The principal caregiver must maintain all documentation as required in the DMH Record Guide.

H. The Host Home agency is responsible for ensuring the individual has basic furnishings in his/her bedroom if those furnishings are not available from another resource such as Bridge to Independence (Money Follows the Person) or Transition Assistance through the ID/DD waiver. Basic furnishings include: bed frame, mattress, box springs if needed, chest of drawers, and appropriate lighting.

I. Individuals receiving Host Home services are not eligible for Home and Community Supports, Shared Supported Living, Supported Living, Supervised Living, In-Home Nursing Respite, In-Home Respite or Community Respite.

J. Individuals receiving Host Home services must be determined to be able to self-administer their medication(s).

K. Individuals receiving Host Home services must have access to the community to the same degree as people not receiving services. This includes access to leisure and other community participation activities.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 30.4 Supported Living Services for IDD Service Components

A. Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Supported Living services are provided in a homelike setting where people have access to the community at large to the same extent as people who do not have a serious mental illness and/or IDD.

B. Supported Living Services are for individuals age 18 and above with serious mental illness and/or intellectual/developmental disabilities and are provided in residences in the community with four (4) or fewer individuals

C. Supported Living provides assistance with the following, depending on each individual's support needs:

1. Grooming
2. Eating
3. Bathing
4. Dressing
5. Personal hygiene.

D. Supported Living provides assistance with instrumental activities of daily living which include assistance with:

1. Planning and preparing meals
2. Transportation or assistance with securing transportation
3. Assistance with ambulation and mobility
4. Supervision of the individual's safety and security
5. Banking
6. Shopping
7. Budgeting
8. Facilitation of the individual's inclusion participation in community activities
9. Use of natural supports and

E. Providers must develop methods, procedures and activities to provide meaningful days and independent living choices about activities/services/staff for the individual(s) served in the community.

F. Procedures must be in place for individual(s) to access any other needed services as well as typical community services available to all people in order to facilitate meaningful days and development of natural supports.

G. For individuals with IDD staff ratios are dependent upon the level of support required by the individual, not to exceed eight (8) hours per twenty-four (24) hour period.

H. Supported Living services for community participation activities may be shared by up to three (3) individuals who may or may not live together and who have a common direct service provider agency. In these cases, individuals may share Supported Living staff when agreed to by the individuals and when the health and welfare can be assured for each individual.

I. Individuals in Supported Living cannot also receive: Supervised Living, Host Home services, In-Home Nursing Respite, In-Home Respite, Home and Community Supports, or Community Respite.

J. Nursing services are a component part of ID/DD Waiver Supported Living. They must be provided as-needed, based on each individual's need for nursing services. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring; periodic assessment, etc.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 30.5 Supported Living for IDD Environment and Safety</u>

A. Each housing unit/house must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the home , (i.e.,

kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

B. Providers must document that all fire extinguishers are properly maintained and serviced. Homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

C. Each housing unit/house must have, at a minimum, operable carbon monoxide detector where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

D. In lieu of posted escape routes, providers must document training that prepares an individual to exit their housing unit/house in the event of emergency.

E. Training for Supported Living must take place upon admission and at least annually thereafter. Documentation is to be maintained in the person's record.

F. At least annually, training must be provided to adults individuals receiving Supported Living Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following:

1. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;
2. Fire, smoke and carbon monoxide safety and the use of detectors. If necessary, staff must assist in obtaining and mounting fire, smoke and carbon monoxide detectors;
3. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature, documenting such in a log to be maintained by the provider staff; and,
4. Any other health/safety issues based on the needs or identified risk for each individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 30.6 Shared Supported Living for IDD Service Components</u>

A. Shared Supported Living services are for individuals age 18 and older who have IDD and are provided in compact geographical areas (e.g. an apartment complex) in residences either owned or lease by themselves or a provider. Staff supervision is provided at the program site and in the community but does not include direct staff supervision at all times. Waiver Supervised Living Program Supervisors may be limited to supervise less than 24 individuals served if deemed necessary by DMH.

1. The amount of staff supervision someone receives is based on tiered levels of support based on a person's score on the Inventory for Client and Agency Planning (ICAP).
2. There must be awake staff twenty-four (24) hours per day, seven (7) days per week when individuals are present. Staff must be able to respond to requests/need for assistance from individuals receiving services within five (5) minutes at all times individuals are present at the program site.

B. Nursing services are a component part of ID/DD Waiver Shared Supported Living. They must be provided as-needed, based on each individual's need for nursing services. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring; periodic assessment, etc.

C. Shared Supported Living provides individuals assistance with direct personal care activities such as:

1. Grooming
2. Eating
3. Bathing
4. Dressing
5. Personal hygiene

D. Shared Supported Living provides assistance with instrumental activities of daily living which include:

1. Planning and preparing meals
2. Transportation
3. Ambulation and mobility
4. Supervision of the individual's safety and security
5. Banking
6. Shopping
7. Budgeting
8. Facilitation of the individual's participation in community activities
9. Use of natural supports and typical community services available to all people in order to facilitate meaningful days

E. Individuals have freedom and support to control their own schedules and activities.

1. Individuals cannot be made to attend a day program if they choose to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if they are ill, or otherwise choose to remain at home.
2. Staff must be available to support individual choice.

F. All required staff must participate in the development and review of the person's Plan of Services and Supports.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 30.7 Shared Supported Living for IDD Environment and Safety

A. Each housing unit/house must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the home , (i.e., flammable storage areas, kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

B. Providers must document that all fire extinguishers are properly maintained and serviced. Homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

C. Each housing unit/house must have, at a minimum, operable carbon monoxide detectors located where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

D. In lieu of posted escape routes, providers must document training that prepares an individual to exit their housing unit/house in the event of emergency.

E. Training must take place upon admission and at least quarterly thereafter. This documentation must be maintained on site, in each person's record.

F. At least annually, training must be provided to adults individuals receiving Supported Living Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following:

1. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;
2. Fire, smoke and carbon monoxide safety and the use of detectors. If necessary, staff must assist in obtaining and mounting fire, smoke and carbon monoxide detectors;
3. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature, documenting such in a log to be maintained by the provider staff; and,
4. Any other health/safety issues based on the needs or identified risk for each resident individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 31: Community Living Services Individuals with Substance Use Disorders

Rule 31.1 General Community Living for Individuals with Substance Use Disorders

A. Substance Use Disorders Residential Treatment Services support individuals as they develop the skills and abilities necessary to improve their health and wellness, live self-directed lives, and strive to reach their full potential in a life of recovery. Services are offered in a community based treatment setting. The residential continuum of care includes both Primary Residential Services and Transitional Residential Services for individuals with SUD.

B. Staffing must be sufficient to meet service requirements. Male and female (as appropriate) staff must be on-site and available twenty-four (24) hours per day, seven (7) days per week.

C. Residential Services accommodating child residents must adhere to the following:

   1. Provide adequate, secure, and supervised play space
   2. Prohibit any form of corporal punishment by staff or individuals receiving services. Staff must provide residents with information regarding positive approaches to management of children's behavior.
   3. Safety measures in place to prohibit access by any child perpetrators/offenders. This includes potential residents or visitors.

D. Programs serving children or youth must also comply with Rule 29.

E. Caseloads for residential services must have no more than twelve (12) adults or eight (8) adolescents assigned to a single therapist or counselor.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.2 Substance Use Disorders Community Living Handbook

A. In addition to information contained in the provider's policy and procedure manual, providers of SUD Residential Treatment Services must develop a Handbook which includes all applicable policies and procedures. Handbooks are to be provided to the individual/parent/legal representative during orientation. The Community Living Handbook must be readily available for review by staff and must be updated as needed.

B. All providers must document that each individual (and/or parent/guardian) served is provided with a handbook during orientation on the day of admission. The provider must document the review of the handbook with the resident annually (if applicable to the service).

C. The service and site-specific handbook must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative.

D. Providers must have a written plan for providing the handbook information in a resident's language of choice when necessary if English is not their primary language.

E. At a minimum, the Handbook must address the following:

1. A person friendly, person first definition and description of the service being provided
2. The philosophy, purpose and overall goals of the service, to include but are not limited to:
   (a) Methods for accomplishing stated goals and objectives
   (b) Expected results/outcomes
   (c) Methods to evaluate expected results/outcomes
3. A description of how the service addresses the following items:
   (a) Visitation guidelines
   (b) External communication guidelines (phone, mail, email, etc.)
   (c) Dating
   (d) Off-site activities
   (e) Household tasks
   (f) Curfew
   (g) Use of items for personal consumption (i.e., tobacco, dietary supplements, OTC medications, food or drink items, etc.
   (h) Respecting the rights of other residents' privacy, safety, health and choices
4. A description of the meal schedule
5. Personal hygiene care and grooming expectations, including assistance available
6. Medication schedule
7. Guidelines for prevention of and protection from infection, including communicable diseases
8. Policy regarding the search of the individual's room, person and/or possessions including:
   (a) Circumstances in which a search may occur
   (b) Staff designated to authorize searches
   (c) Documentation of searches
   (d) Consequences of discovery of prohibited items
9. Policy regarding urine drug screening for prohibited/illegal substances including:
   (a) Circumstances in which screens may occur
   (b) Staff designated to authorize screening
   (c) Documentation of screening
   (d) Consequences of positive screening of prohibited substances
   (e) Consequences of refusing to submit to a screening
   (f) Process for individuals to confidentially report the use of prohibited substances prior to being screened

10. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights

F. Orientation of the individual to the service including:

1. Familiarization of the individual with the living arrangement and neighborhood
2. Introduction to support staff and other residents (if appropriate)
3. Description of the written materials provided upon admission (i.e., handbook, etc.)
4. Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission

G. Methods for assisting individuals in arranging and accessing routine and emergency medical and dental care including:

1. Agreements with local physicians and dentists to provide routine care
2. Agreements with local physicians, hospitals and dentists to provide emergency care
3. Process for gaining permission from parent/guardian, if necessary

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.3 Animals/Pets on the Premises

A. Providers must develop policies regarding pets and animals on the premises for all community living programs.

B. Animal/Pet policies must address, at a minimum, the following:

7. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
8. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
9. Procedures to ensure pets will be kept away from food preparation sites and eating areas
10. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.4 Transitional Residential Services

A. Transitional Residential Services are provided in a safe and stable group living environment which promotes recovery while encouraging the pursuit of vocational or related opportunities.

B. An individual must have successfully completed a primary residential substance use disorder treatment program in order to be eligible for admission to transitional residential services. The primary substance use disorder residential treatment program must be at least four (4) weeks long.

C. The program components include at a minimum:

1. At least one (1) hour of individual therapy per week with each individual
2. A minimum attendance of at least two (2) hours of group therapy per week. Group therapy must be offered at times that accommodate the schedules of the individuals
3. Family therapy must be offered and available as needed. Documentation of attendance or refusal is required.
4. Psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, vocation, education, employment, recovery, or related skills.
5. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval)

D. A written master schedule of activities that documents the provision of the following services:

1. Group therapy
2. Psychoeducational groups
3. Therapeutic and leisure/recreational/physical exercise activities

E. Employment for individuals in Transitional Residential Services must be community based and not as part of the onsite program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.5 Primary Residential Services

A. Primary Residential Services is the highest community based level of care for the treatment of substance use/addictive disorders. This level of treatment provides a safe and stable group living environment where the individual can develop, practice and demonstrate necessary recovery skills.

B. Individuals admitted into Primary Residential Services must receive a medical assessment within forty-eight (48) hours of admission to screen for health risks

C. Programs must ensure access to each of the following professionals either through program staff or affiliation agreement/contract:

1. A licensed psychiatrist or psychologist with experience in the treatment of substance use disorders or
2. A licensed physician with experience in the treatment of substance use disorders.

D. The program components include at a minimum:

1. At least one (1) hour of individual therapy per week with each individual.
2. A minimum attendance of at least five (5) hours of group therapy per week with each individual.
3. Family therapy must be offered and available at least twice (2) during the course of treatment. Documentation of attendance or refusal by the individual or family is required.
4. At least twenty (20) hours of psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, substance use disorders, self-help/personal growth, increasing self-esteem, wellness education, social skills, anger management, the recovery process, and a philosophy of living which will support recovery.
5. At least three (3) hours of family-oriented education activities during the course of treatment.
6. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval)
7. Vocational counseling and planning/referral for follow-up vocational services
8. For child/youth, an academic schedule indicating school hours.

E. A written master schedule that documents the provision of the following services:

1. Group therapy
2. Psychoeducational groups
3. Family-oriented education
4. Therapeutic and leisure/recreational/physical exercise activities
5. Vocational counseling and planning/referral
6. For child/youth, an academic schedule indicating school hours

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.6 Environment and Safety for Primary and Transitional Residential Services

A. Programs must adhere to environmental and safety requirements in this section that are in addition to or more stringent than the requirements in Chapter 13 and are specific to Primary and Transitional Services.

B. The provider must assign, maintain and document on-site staff coverage twenty-four (24) hours a day and seven (7) days a week with a staff member designated as responsible for the program at all times and male/female staff coverage when necessary.

C. All providers must ensure adequate visiting areas are provided for residents and visitors.

D. All providers must ensure the laundry room has an exterior mechanical ventilation system for the clothes dryer.

E. All programs must have separate storage areas for:

1. Sanitary linen;
2. Food (Food supplies cannot be stored on the floor.); and
3. Cleaning supplies.

F. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

G. All program of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system (all systems must be operable).

H. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas;

I. Programs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas;

J. Each bedroom must have at least two means of escape

K. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom; and,

L. Two (2) means of exit per living area must be provided and must be readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition.

M. Programs must have the capacity to monitor unauthorized entrance, egress, or movement through the facility; and,

N. Resident bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor. All windows must be operable.

O. Resident bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

P. Resident bedrooms must house no more than three (3) persons each;

Q. Resident bedrooms must be appropriately furnished with a minimum of a single bed and chest of drawers and adequate storage/closet space for each resident;

R. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances;

S. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and

T. Each bed must be equipped with a minimum of one pillow and case, two sheets, bedspread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

U. All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

V. All programs must ensure bathtubs and showers are equipped with:

1. Soap dishes;
2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 32 Programs of Assertive Community Treatment (PACT)

Rule 32.1 Service Components of Programs of Assertive Community Treatment (PACT)

A. A Program of Assertive Community Treatment (PACT) is an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

B. The important characteristics of Programs of Assertive Community Treatment (PACT) are:

1. PACT serves individuals who may have gone without appropriate services. Consequently, the individual group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.

2. PACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services individuals need to achieve their goals. Many, if not all, staff share responsibility for addressing the needs of all individuals requiring frequent contact.

3. PACT services are individually tailored with each individual and address the preferences and identified goals of each individual. The approach with each individual emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.

4. The PACT team is mobile and delivers services in community locations to enable each individual to find and live in their own residence and find and maintain work in community jobs rather than expecting the individual to come to the program.

5. PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many individuals benefit from the availability of a longer-term treatment approach and continuity of care. This allows individuals opportunity to decompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.2 PACT Staffing

A. Each PACT team must have the organizational capacity to provide a minimum staff-to-

individual ratio of at least one (1) full-time equivalent (FTE) staff person for every ten (10) individuals (this ratio does not include the psychiatrist or psychiatric nurse practitioner and the program assistant).

B. Each PACT team must have sufficient numbers of staff to provide treatment, rehabilitation, and support services twenty-four (24) hours a day, seven (7) days per week.

C. In addition to meeting the qualifications outlined in Part 2: Chapter 11, the following positions are required for PACT Teams:

1. Team Leader: A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the PACT team. At a minimum, this individual must have a Master's degree in a mental health or related field and professional license or DMH credentials as a Certified Mental Health Therapist.
2. Psychiatrist/Psychiatric Nurse Practitioner: A psychiatrist/psychiatric nurse practitioner, who works on a full-time or part-time basis for a minimum of sixteen (16) hours per week for every fifty (50) individuals. For teams serving over fifty (50) individuals, the psychiatrist/psychiatric nurse practitioner must provide an additional three hours per week for every fifteen (15) additional individuals admitted to the program (not including on call time.) The psychiatrist/psychiatric nurse practitioner provides clinical services to all PACT individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.
3. At least two (2) Full-time registered nurses. A team leader with a nursing degree cannot replace one of the FTE nurses.
4. At least one (1) Master's level or above mental health professional (in addition to the team leader.)
5. At least one (1) Substance Abuse Specialist
6. At least one (1) Employment Specialist
7. At least one (1) FTE certified peer specialist. Peer specialists must be fully integrated team members.
8. The remaining clinical staff may be Bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions. A Bachelor's level mental health worker has a Bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A para-professional mental health worker may have a Bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-service needs. These paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.
9. At least one (1) program assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of PACT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and

providing receptionist activities, including triaging calls and coordinating communication between the team and individuals.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.3 PACT Admissions and Discharge

A. In order to be admitted into PACT services, individuals must meet the criteria outlined in this rule.

B. PACT Teams serve individuals with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder, intellectual disability or other Axis II disorders are not the intended individual group. Additionally, individuals with a chronically violent history may not be appropriate for this service.)

C. Individuals with significant functional impairments as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

D. Individuals must have one or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight hours per month):

1. High use of acute psychiatric hospitals (e.g., two [2] or more admissions per year) or psychiatric emergency services.
2. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
3. Coexisting substance abuse disorder of significant duration (e.g., greater than six [6] months).

4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or in imminent risk of becoming homeless.
6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
7. Difficulty effectively utilizing traditional office-based outpatient services.

E. Discharges from the PACT team occur when individuals and program staff mutually agree to the termination of services. This must occur when individuals:

1. Have successfully reached individually established goals for discharge, and when the individual and program staff mutually agrees to the termination of services.
2. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the individual requests discharge, and the program staff mutually agree to the termination of services.
3. Move outside the geographic area of PACT's responsibility. In such cases, the PACT team must arrange for transfer of mental health service responsibility to a PACT program or another provider wherever the individual is moving. The PACT team must maintain contact with the individual until this service transfer is implemented.
4. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable Individual Service Plan with the individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 32.4 PACT Contacts</u>

A. The PACT team must have the capacity to provide multiple contacts during a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three (2 – 3) times per day, seven (7) days per week and depend on individual need and a mutually agreed upon plan between individuals and program staff. Many, if not all, staff must share responsibility for addressing the needs of all individuals requiring frequent contact.

B. The PACT team must have the capacity to rapidly increase service intensity to an individual when his or her status requires it or an individual requests it.

C. The PACT team must provide a mean (i.e., average) of at least three (3) contacts per week for all individuals.

D. Each new PACT team must gradually build up its case load with a maximum admission rate of five (5) individuals per month.

E. The PACT team must be available to provide treatment, rehabilitation, and support activities seven (7) days per week. When a team does not have sufficient staff numbers to operate two (2) eight (8) hour shifts weekdays and one (1) eight (8) hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on an individual-by-individual basis (per the individual-centered comprehensive assessment and individualized Individual Service Plan) in the evenings and on weekends. This includes:

1. Regularly scheduling staff to cover individual contacts in the evenings and on weekends.
2. Regularly scheduling mental health professionals for on-call duty to provide crisis and other services the hours when staff are not working.
3. The team may arrange coverage through a reliable crisis-intervention service. The team must communicate routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to individuals who may need assistance and to provide effective ways for helping them). The crisis-intervention service should be expected to go out and see individuals who need face-to-face contact.
4. Regularly arranging for and providing psychiatric backup all hours the psychiatrist/psychiatric nurse practitioner is not regularly scheduled to work. If availability of the PACT psychiatrist/psychiatric nurse practitioner during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).
5. If “3” or “4” occurs, memoranda of agreement or formal contracts should be established and kept on file by the provider.

F. Each PACT Team must set a goal of providing eighty-five percent (85 percent) of service contacts in the community in non-office-based or non-facility-based settings.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 32.5 PACT Staff Communication and Planning</u>

A. The PACT team must conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

1. The PACT team must maintain a written daily log. The daily log provides:
   (a) A roster of the individuals served in the program; and
   (b) For each individual, a brief documentation of any treatment or service contacts that have occurred during the last twenty-four (24) hours and a concise, behavioral description of the individual’s status that day.
2. The daily organizational staff meeting must commence with a review of the daily log to update staff on the treatment contacts which occurred the day before and to provide

a systematic means for the team to assess the day-to-day progress and status of all individuals.

3. The PACT team, under the direction of the team leader, must maintain a weekly individual schedule for each individual. The weekly individual schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the individual's Individual Service Plan. The team will maintain a central file of all weekly individual schedules.
4. The PACT team, under the direction of the team leader, must develop a daily staff assignment schedule from the central file of all weekly individual schedules. The daily staff assignment schedule is a written timetable for all the individual treatment and service contacts and all indirect individual work (e.g., medical record review, meeting with collaterals [such as employers, social security], job development, Individual Service Planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.
5. The daily organizational staff meeting will include a review of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the team leader or designee will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, and the team leader will be responsible for assuring that all tasks are completed.
6. During the daily organizational staff meeting, the PACT team must also revise Individual Service Plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised Individual Service Plans.

B. The PACT team must conduct Individual Service Planning meetings under the supervision of the team leader and the psychiatrist/psychiatric nurse practitioner. These Individual Service Planning meetings must:

1. Convene at regularly scheduled times per a written schedule set by the team leader.
2. Occur and be scheduled when the majority of the team members can attend, including the psychiatrist/psychiatric nurse practitioner, team leader, and all members of the Individual Treatment Team.
3. Require individual staff members to present and systematically review and integrate individual information into a holistic analysis and prioritization of issues.
4. Occur with sufficient frequency and duration to make it possible for all staff:
   (a) to be familiar with each individual and their goals and aspirations;
   (b) to participate in the ongoing assessment and reformulation of issues/ problems;
   (c) to problem-solve treatment strategies and rehabilitation options;
   (d) to participate with the individual and the Individual Treatment Team in the development and the revision of the Individual Service Plan; and
   (e) to fully understand the Individual Service Plan rationale in order to carry out each individual's plan.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.6 PACT Staff Supervision

A. Each PACT team must develop a written policy for clinical supervision of all staff providing treatment, rehabilitation, and support services. The team leader and psychiatrist must assume responsibility for supervising and directing all staff activities. This supervision and direction must consist of:

   1. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with individuals in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment approaches;
   2. Participation with team members in daily organizational staff meetings and regularly scheduled Individual Service Planning meetings to review and assess staff performance and provide staff direction regarding individual cases;
   3. Regular meetings with individual staff to review their work with individuals, assess clinical performance, and give feedback;
   4. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, Individual Service Plans, Individual Service Plan reviews); and
   5. Written documentation of all clinical supervision provided to PACT team staff.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.7 PACT Required Services

A. Operating as a continuous treatment service, the PACT team must have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit. Services must minimally include the following (1-11):

   1. Service Coordination/Individual Treatment Team
      (a) Each individual will be assigned one (1) member of the PACT team to serve as a service coordinator who coordinates and monitors the activities of the person's Individual Treatment Team (ITT) and the greater PACT team. The primary responsibility of the service coordinator is to work with the individual to write the Individual Service Plan, to provide individual supportive counseling, to offer options and choices in the Individual Service Plan, to ensure that immediate changes are made as the individual's needs change, and to advocate for the individual's wishes, rights, and preferences. The service coordinator is also the first staff person called on when the individual is in crisis and is the primary support person and educator to the individual and/or individual's family. Members of the individual's treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.
      (b) Each individual will be assigned to Individual Treatment Team (ITT.) The ITT is a group or combination of three (3) to five (5) PACT staff members who together

have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned to work with an individual receiving services by the team leader and the psychiatrist/psychiatric nurse practitioner by the time of the first Individual Service Planning meeting or thirty (30) days after admission. The core members of the ITT are the service coordinator, the psychiatrist/psychiatric nurse practitioner, and one (1) clinical or rehabilitation staff person who shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The ITT has continuous responsibility to: 1) be knowledgeable about the individual's life, circumstances, goals and desires; 2) collaborate with the individual to develop and write the Individual Service Plan; 3) offer options and choices in the Individual Service Plan; 4) ensure that immediate changes are made as an individual's needs change; and 5) advocate for the individual's wishes, rights, and preferences. The ITT is responsible to provide much of the individual's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles with the individual as specified by the individual and the ITT in the Individual Service Plan.

2. Crisis Assessment and Intervention
   (a) Crisis assessment and intervention must be provided twenty-four (24) hours per day, seven (7) days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local community mental health system's emergency services program as appropriate.
   (b) A system must be in place that assures the individual can contact the PACT as necessary.

3. Symptom Assessment and Management include but not limited to the following:

   (a) Ongoing comprehensive assessment of the individual's mental illness symptoms, accurate diagnosis, and the individual's response to treatment.
   (b) Psycho-education regarding mental illness and the effects and side effects of prescribed medications.
   (c) Symptom-management efforts directed to help each individual identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
   (d) Individual supportive therapy.
   (e) Psychotherapy.
   (f) Generous psychological support to individuals, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.

4. Medication Prescription, Administration, Monitoring and Documentation

   (a) The PACT team psychiatrist/psychiatric nurse practitioner must:

      (1) Establish an individual clinical relationship with each individual.
      (2) Assess each individual's mental illness symptoms and provide verbal and written information about mental illness.

(3) Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist/psychiatric nurse practitioner will follow.
(4) Provide education about medication, benefits and risks, and obtain informed consent.
(5) Assess and document the individual's mental illness symptoms and behavior in response to medication and monitor and document medication side effects
(6) Provide psychotherapy.

(b) All PACT team members must regularly assess and document the individual's mental illness symptoms and behavior in response to medication and must monitor for medication side effects. This information should be shared with the prescriber.
(c) The PACT team program must establish medication policies and procedures which identify processes to:

(1) Record physician orders;
(2) Order medication;
(3) Arrange for all individual medications to be organized by the team and integrated into individuals' weekly schedules and daily staff assignment schedules;
(4) Provide security for medications (e.g., daily and longer-term supplies, long-term injectables, and longer term supplies) and set aside a private designated area for set up of medications by the team's nursing staff;
(5) Administer medications per state law to individuals receiving PACT services; and
(6) Comply with Rule 13.8.

5. Co-Occurring Substance Abuse Services

(a) Co-Occurring Substance Abuse Services are the provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has individual-determined goals. This must include but is not limited to individual and group interventions in:
(1) Engagement (e.g., empathy, reflective listening, avoiding argumentation).
(2) Assessment (e.g., stage of readiness to change, individual-determined problem identification).
(3) Motivational enhancement (e.g., developing discrepancies, psycho-education)
(4) Active treatment (e.g., cognitive skills training, community reinforcement).
(5) Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

6. Work-Related Services

(a) Work-related services to help individuals value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and

coordinate with employers but also includes but is not necessarily limited to:

(1) Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.

(2) Assessment of the effect of the individual's mental illness on employment with identification of specific behaviors that interfere with the individual's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

(3) Development of an ongoing employment plan to help each individual establish the skills necessary to find and maintain a job.

(4) Individual supportive therapy to assist individuals to identify and cope with mental illness symptoms that may interfere with their work performance.

(5) On-the-job or work-related crisis intervention.

(6) Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

7. Activities of Daily Living

(a) Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist individuals to gain or use the skills required to:

(1) Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating); and procuring necessities (such as telephones, furnishings, linens).

(2) Perform household activities, including house cleaning, cooking, grocery shopping, and laundry.

(3) Carry out personal hygiene and grooming tasks, as needed.

(4) Develop or improve money-management skills.

(5) Use available transportation.

(6) Have and effectively use a personal physician and dentist.

8. Social/Interpersonal Relationship and Leisure-Time Skill Training

(a) Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure individuals' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

(1) Improve communication skills, develop assertiveness, and increase self-

esteem.
(2) Develop social skills, increase social experiences, and develop meaningful personal relationships.
(3) Plan appropriate and productive use of leisure time.
(4) Relate to landlords, neighbors, and others effectively.
(5) Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities.

9. Peer Support Services

(a) Services to validate individuals' experiences and to guide and encourage individuals to take responsibility for and actively participate in their own recovery. In addition, services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma;
(b) Peer counseling and support; and
(c) Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.

10. Support Services

(a) Support services or direct assistance to ensure that individuals obtain the basic necessities of daily life, including but not necessarily limited to:
(1) Medical and dental services;
(2) Safe, clean, affordable housing;
(3) Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance);
(4) Social services;
(5) Transportation; and
(6) Legal advocacy and representation.

11. Education, Support, and Consultation to Individuals' Families and Other Major Supports

(a) Services provided regularly under this category to individuals' families and other major supports, with individual agreement or consent, include:
(1) Individualized psycho-education about the individual's illness and the role of the family and other significant people in the therapeutic process;
(2) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people;
(3) Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family;
(4) Introduction and referral to family self-help programs and advocacy organizations that promote recovery;
(5) Assistance to individuals with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

i. Services to help individuals throughout pregnancy and the birth of a child;
ii. Services to help individuals fulfill parenting responsibilities and coordinate services for the child/children; and
iii. Services to help individuals restore relationships with children who are not in the individual's custody.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.8 PACT Stakeholder Advisory

A. The PACT team must have a stakeholder advisory group to support and guide PACT team implementation and operation. The stakeholder advisory group must be made up of at least 51 percent (51%) mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer-support organizations, food-shelf agencies, faith-based groups, criminal justice system, housing authorities, landlords, employers, and/or community colleges. Group membership must also represent the cultural diversity of the local population.

B. The stakeholder advisory group must:

1. Promote quality PACT model programs;
2. Monitor fidelity to the PACT program standards;
3. Guide and assist with the administering agency's oversight of the PACT program;
4. Problem-solve and advocate to reduce system barriers to PACT implementation;
5. Review and monitor individual and family grievances and complaints; and
6. Promote and ensure individuals' empowerment and recovery values in assertive community treatment programs.

C. The PACT team must have a system for regular review of the service that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 33: Adult Making A Plan (AMAP) Teams

Rule 33.1 AMAP – General Requirements

A. Adult Making a Plan (AMAP) Teams address the needs of adults, 18 years and above, with serious mental illness or dually diagnosed (SMI/DD or SMI/SUD) who have frequent/multiple placements in inpatient psychiatric services which could possibly be prevented with the coordinated efforts of multiple agencies and services.

B. Each AMAP Team must have a staff member identified as the Coordinator employed by the provider who has a Bachelor's degree. In addition, the following team members are recommended and should be present and documented at each AMAP Team meeting (if applicable):

   1. The individual being referred to the AMAP Team, family member, and/or advocate representing the individual.
   2. The individual's therapist, community support specialist, or other staff from the provider which have detailed knowledge of the individual.
   3. A representative of the Chancery Clerks office or Chancery Court.
   4. A representative of the sheriff's department of the county in which the individual resides; and/or representative of the police department of the city of residence.
   5. Staff from the regional behavioral health program or crisis stabilization unit that has had frequent contact with the individual.

C. The provider must maintain a current written interagency agreement with agencies participating in the AMAP Team.

D. The overall goal of the AMAP Team is to develop a new and different intervention for the individual in order for them to have a greater success of being maintained in a community setting. Past course of treatment and altered future service plan and completion of Crisis Support Plan must be documented on the Case Summary Form.

E. AMAP Team Monthly Reporting form and AMAP Team Case Summary forms must be submitted to DMH with each cash reimbursement request (if funding is available) and must also be maintained on-site with the AMAP Team Coordinator.

F. For any individuals who have been previously referred to the local AMAP Team to be placed at/committed to an inpatient psychiatric facility, the local AMAP Team must attempt to develop a less restrictive alternative in the community.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 33.2 Access to AMAP Teams

A. All providers certified as Community Mental Health Centers (DHM/C) must have a minimum of one (1) AMAP Team Coordinator.

B. The AMAP Team Coordinator must provide information about the AMAP Team to all Chancery Clerks and Sheriff's Departments of every county in the CMHC catchment area.

C. The AMAP Team Coordinator must provide information about their AMAP Team (i.e. contact person, meeting schedule, etc.) to each state operated behavioral health facility, DMH certified Crisis Stabilization Unit that has a catchment area that their CMHC falls in, and the DMH Office of Consumer Support.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 34: Access to Inpatient Care

Rule 34.1 Referral

A. All providers certified as DMH/C or DMH/P must provide access to inpatient services in the individual's locale when appropriate.

B. The provider must have written policies and procedures for referral to inpatient services in the community, should an individual require such services.

C. The provider must maintain a current written agreement with a licensed hospital(s) to provide/make available inpatient services, which, at a minimum, addresses:

   1. Identification of the provider's responsibility for the individual's care while the individual is in inpatient status;
   2. Description of services that the hospitals will make available to individuals who are referred; and,
   3. How hospital referral, admission and discharge processes are coordinated with crisis, Pre-Evaluation Screening, Civil Commitment Examination Services, and aftercare services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 34.2 Pre-Evaluation Screening and Civil Commitment

A. Pre-Evaluation Screening and a Civil Commitment Examination are two separate events which include screening and examinations, inclusive of other services to determine the need for civil commitment and/or other mental health services, including outpatient or inpatient commitment. These services also include assessment and plans to link individuals with appropriate services and can only be provided by a DMH/C.

B. The DMH/C must have a written plan that has been implemented which describes how the program meets the requirements of the Mississippi civil commitment statutes. This plan must describe by county:

   1. The system for conducting Pre-Evaluation Screenings
   2. The system for conducting Civil Commitment Examinations
   3. The system for handling court appearances
   4. The services that are offered for the family and/or significant others
   5. The system for assuring that individuals being screened and/or evaluated for civil commitment and their family or significant others have access to a staff member knowledgeable in the civil commitment process.

C. The Pre-Evaluation Screening must be conducted by qualified staff of a regional CMHC, and

1. Be performed by:
   (a) A certified licensed psychologist or physician; or
   (b) A person with a Master's degree in a mental health or related field who has received training and certification in Pre-Evaluation Screening by the DMH; or,
   (c) Registered nurses who have received training and certification in Pre-Evaluation Screening by the DMH.
   (d) Additionally, staff who meet requirements (b) and (c) above, have completed and provide documentation of at least six (6) months of experience working with individuals with SMI or SED and;
2. Be performed in accordance with current Mississippi civil commitment statutes.
3. Be documented on the forms and provide the information required by the civil commitment law and/or the DMH.

D. If the Civil Commitment Examination is conducted, the examination must:

1. Be performed by two (2) licensed physicians, or one (1) licensed physician and either one (1) psychologist, nurse practitioner or physician assistant. The nurse practitioner or physician assistant conducting the examination shall be independent from, and not under the supervision of, the other physician conducting the examination (as required in MCA Section 41-21-67 (2)).
2. Be documented on required forms, and provide information required by law or the DMH. Documentation must include information in the individual record of the Commitment Examination results and the official disposition following the examination
3. Include the evaluation of the individual's social and environmental support systems
4. Include, when possible, the development of a treatment and follow-up plan for the individual and the family and/or significant others.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 35: Designated Mental Health Holding Facilities

Rule 35.1 Designation

Designated Mental Health Holding Facilities (hereafter referred to as "Holding Facility") hold individuals who have been involuntarily civilly committed and are awaiting transportation to a treatment facility. The Holding Facility can be a county facility or a facility in which the county contracts. DMH will conduct annual on-site visits to each Holding Facility to ensure they are in compliance with the standards in this Chapter.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.2 Policies and Procedures

A. Each Holding Facility must have a manual that includes the written policies and procedures for operating and maintaining the facility holding individuals involved in the civil commitment process or those awaiting transportation to a certified/licensed mental health facility. Written policies and procedures must give sufficient details for implementation and documentation of duties and functions so that a new employee or someone unfamiliar with the operation of the Holding Facility and services would be able to carry out necessary operations of the Holding Facility.

B. The policies and procedures must:

1. Be reviewed annually by the governing authority of the county, with advice and input from the regional Community Mental Health Center, as documented in the governing authority meeting minutes;
2. Be updated as needed, with changes approved by the governing authority before they are instituted, as documented in the governing authority meeting minutes. Changed sections, pages, etc., must show the date of approval of the revision on each page;
3. Be readily accessible to all staff on all shifts providing services to individuals in the Holding Facility, with a copy at each service delivery location;
4. Describe how the policies and procedures are made available to the public;
5. Have a copy of the Memorandum of Understanding (MOU) or contract between the Holding Facility and the Community Mental Health Center to describe how mental health services will be provided while people are being held in the Holding Facility.

C. A personnel record for each employee/staff member and contractual employee, as noted below, must be maintained and must include, but not be limited to:

1. The application for employment, including employment history and experience;
2. A copy of the current Mississippi license or certification for all licensed or certified personnel;

3. A copy of college transcripts, high school diploma, and/or appropriate documents to verify that educational requirements of the job description are met;
4. Documentation of an annual performance evaluation;
5. A written job description that shall include, at a minimum:
   (a) Job title;
   (b) Responsibilities of the job; and
   (c) Skills, knowledge, training/education and experience required for the job;
6. For contractual employees, a copy of the contract or written agreement which includes effective dates of the contract and which is signed and dated by the contractual employee and the Director of the Holding Facility or County Supervisor;
7. For all staff (including contractual staff) and volunteers, documentation must be maintained that a criminal records background check (including prior convictions under the Vulnerable Adults Act) and child registry check (for staff and volunteers who work with or may have to work with children) has been obtained and no information received that would exclude the employee/volunteer. (See Sections 43-15-6, 43-20-5, and 43-20-8 of the *Mississippi Code of 1972, Annotated*.) For the purposes of these checks, each employee/volunteer hired after July 1, 2002, must be fingerprinted;

D. Each facility shall have written procedures for admission of individuals who have been involuntarily civilly committed and awaiting transportation. These procedures shall include, but not be limited to, the following:

1. Make a complete search of the individual and his/her possessions;
2. Properly inventory and store individual's personal property;
3. Require any necessary personal hygiene activities (e.g., shower or hair care, if needed);
4. Issue clean, laundered clothing or appropriate garments (e.g., suicide risk reduction garments);
5. Issue allowable personal hygiene articles;
6. Perform health/medical screening;
7. Record basic personal data and information to be used for mail and visiting lists; and
8. Provide a verbal orientation of the individual to the facility and daily routines.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.3 Staff Training

A. Supervisory and direct service staff who work~~s~~ with individuals being held in the Holding Facility as part of the civil commitment process must participate in training opportunities and other meetings, as specified and required by the Mississippi Department of Mental Health.

B. Documentation of training of individual staff must be included in individual training/personnel records and must include:

1. Date of training;
2. Topic(s) addressed;
3. Name(s) of presenter(s) and qualifications;
4. Contact hours (actual time spent in training).

C. Training on the following must be conducted and/or documented prior to service delivery for all newly hired staff (including contractual staff) and annually thereafter for all program staff. Persons who are trained in the medical field (i.e., physicians, nurse practitioners or licensed nurses) may be excluded from this prior training. Persons who have documentation that they have received this training at another program approved by the Department of Mental Health within the timeframe required may also be excluded:

1. First aid and life safety, including handling of emergencies such as choking, seizures, etc.;
2. Preventing, recognizing and reporting abuse/neglect, including provisions of the Vulnerable Adults Act, and the Mississippi Child Abuse Law;
3. Handling of accidents and roadside emergencies (for programs transporting only);
4. De-escalation techniques & crisis intervention;
5. Confidentiality of information pertaining to individuals being housed in the facility, including appropriate state and federal regulations governing confidentiality, particularly in addressing requests for such information;
6. Fire safety and disaster preparedness to include:
   (a) Use of alarm system;
   (b) Notification of authorities who would be needed/require contact in an emergency;
   (c) Actions to be taken in case of fire/disaster; and
   (d) Use of fire extinguishers;
7. Cardiopulmonary Resuscitation (CPR) certification Recognizing and reporting serious incidents, including completion and submission of reports;
8. Universal precautions for containing the spread of contaminants;
9. Adverse medication reaction and medical response; and
10. Suicide precautions.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 35.4 Environment and Safety</u>

A. If the designated mental health Holding Facility is being used for civil commitment purposes and is part of a correctional facility or jail, the individual(s) awaiting transfer related to civil commitment proceedings (or just individual(s) detained as part of the civil commitment process) must be held separately from pre-trial criminal offense detainees or inmates serving sentences.

B. Rooms used for holding individuals must be free from structures and/or fixtures that could be used to harm themselves.

C. Holding facilities must be inspected and approved by appropriate local and/or state fire, health/sanitation, and safety agencies at least annually (on or before anniversary date of previous inspection), with written records of fire and health inspections on file.

D. The following must be conducted immediately upon arrival:

1. Suicide assessment (using a DMH approved screening instrument); and
2. Violence risk assessment (using a DMH approved screening instrument)

E. If the risk level for any of these assessments is deemed "high", a twenty-four (24) hour follow-up assessment by nurse or physician is required.

F. If the risk level for suicide is deemed "high", immediate suicide prevention actions must be instituted.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.5 Clinical Management

A. Each Holding Facility must have written procedures and documentation for clinical management of individuals who are involved in or have been involuntarily civilly committed and awaiting transportation. These procedures shall include, but not be limited to, the following:

1. Immediately upon arrival of the individual to the Holding Facility, all mental health screening information (pursuant to civil commitment procedures) must be made available to the Holding Facility staff;
2. Immediately upon arrival or within twenty-four (24) hours, a medical screening should be conducted and documented by a registered nurse or nurse practitioner that includes, at a minimum, the following components:
   (a) Vital signs (at a minimum: body temperature, pulse/heart rate, respiratory rate, & blood pressure);
   (b) Accu-Chek monitoring for persons with diabetes;
   (c) Medical/drug history;
   (d) Allergy history; and
   (e) Psychiatric history (refer to pre-evaluation form).

B. Clinical Management of the individual being held must include:

1. Within seventy-two (72) hours of admission, individuals should be assessed by a Physician, preferably a psychiatrist or a Nurse practitioner, preferably a psychiatric nurse practitioner;
2. Twenty-four (24) hour crisis/on-call coverage by a physician or psychiatric nurse practitioner;

3. Availability of ordered pharmacologic agents within twenty-four (24) hours
4. Timely administration of prescribed medication in accordance with the MS Nursing Practice Act;
5. Access to medical services for preexisting conditions that require ongoing medical attention (e.g. high blood pressure, diabetes, etc.);
6. Immediate availability of a limited supply of injectable psychotropic medications, medications for urgent management of non-life threatening medical conditions (e.g., insulin, albuterol inhalers and medications used for withdrawal management);
7. Ongoing assessment and monitoring for persons with mental illness or substance abuse considered by medical or psychiatric staff to be at high risk;
8. Training/certification of staff in prevention/management of aggressive behavior program; and
9. Procedures for maintenance of clinical records, including:
   (a) Documentation of information by professional staff across disciplines;
   (b) Documentation of physician's orders;
   (c) Basic personal data and information that ensures rapid emergency contact, if needed.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.6 Dignity of Individuals

A. In order to ensure the dignity and rights of individuals being held in a facility for reasons of psychiatric crisis or civil commitment, reasonable access to the following must be allowed:

   1. Protection and advocacy services/information;
      (a) Disability Rights MS 800-772-4057;
      (b) Dept. of Mental Health 877-210-8513;
   2. Chaplain services;
   3. Telephone contact; and
   4. Visits with family members.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 36: Consultation and Education Services

Rule 36.1 Written Plan

A. The provider of the Consultation and Education Services must develop and implement a written plan to provide these services. The plan must include a range of activities for:

   1. Developing and coordinating effective mental health education, consultation, and public information programs; and
   2. Increasing the community awareness of mental health related issues.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 36.2 Target Populations

A. The Consultation and Education Services must be designed to specifically meet the needs of the target populations of:

   1. Children and youth;
   2. Elderly persons;
   3. Individuals with serious mental illness;
   4. Individuals with intellectual/developmental disabilities;
   5. Individuals with a co-occurring diagnosis (MH/SUD/IDD);
   6. Individuals with a mental illness who are homeless;
   7. Military families and the military community; and
   8. Other populations defined by the provider.

B. The provider must develop linkages with other health and social agencies that serve the target populations.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 37: Prevention/Early Intervention for SED

Rule 37.1 Service Design

A. Prevention/Early Intervention Services include preventive mental health programs targeting vulnerable at-risk groups with the intent to prevent the occurrence of mental and/or emotional problems and service programs designed to intervene as early as possible following the identification of a problem. Prevention and/or early intervention programs should be designed to target a specific group of children/youth and/or their families, such as children/youth who have been abused or neglected, teenage parents and their children, and young children and their parents. Children/youth identified as having a serious emotional disturbance and/or their families may also be targeted to receive specialized intervention early in the course of identification of the emotional disturbance.

B. A staff member must be designated to plan, coordinate and evaluate Prevention/Early Intervention Services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 37.2 Strategies

A. All Prevention/Early Intervention programs must maintain documentation that services include, but are not limited to, the following:

1. Informational activities designed to provide accurate and current information about emotional disturbance and mental illness in children/youth; or
2. Effective education activities, such as parent education, designed to assist individuals in developing or improving critical life skills and to enhance social competency thereby changing the conditions that reinforce inappropriate behavior; or
3. Consultation/education activities that are designed to include, but not be limited to, education and awareness activities to assist in the maintenance and/or improvement of services; or
4. Early Intervention services, including screening, assessment, referral, counseling, and/or crisis intervention services, designed to serve individuals identified as "high risk" and who are exhibiting signs of dysfunctional behaviors.

B. Development of linkages with other health and social service agencies, particularly with those serving children.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 37.3 Documentation

A. Case records for persons provided individualized Primary Prevention or Early Intervention/Prevention Services (such as home-based individual education, parent or sibling group education, screening/assessment or crisis intervention services) must be maintained with applicable forms in the DMH Record Guide.

B. Documentation of the provision of general or indirect presentations/activities on prevention and/or early intervention must include, at a minimum:

   1. Topic and brief description of the presentation/activity
   2. Group or individuals to whom the activity was provided
   3. Date of activity
   4. Number of participants
   5. Name and title of presenter(s) of activity, with brief description of their qualifications/experience in the topic presented.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 38: Family Support and Education Services

Rule 38.1 Service Design

A. Family Support and Education Services, provide self-help and mutual support for families of children and youth with serious emotional disturbances or mental health challenges. This service increases the knowledge, skills and confidence of parents and family members in parenting their child/youth.

B. A staff member with documented training completed at a successful level in a DMH-approved program in family education and support for families of children/youth with behavioral/conduct or emotional disorders must be designated to coordinate family education and family support services.

C. The provider of Family Support and Education Services must maintain policies and procedures for offering and implementing appropriate family education and family support to families of children/youth with behavioral/conduct or emotional disorders that address, at a minimum, the following:

1. Description of individuals targeted to receive Family Support and Education Services;
2. Specific strategies to be used for outreach to the target population for Family Support and Education Services;
3. Description of qualifications and specialized training required for family support and education providers; and
4. Description of service components of Family Support and Education Services.

D. A variety of family education activities appropriate for families of children/youth with behavioral/conduct or emotional disorders must be made available through pamphlets, brochures, workshops, social activities, or other appropriate meetings or methods/types of presentations with an individual family or groups of families.

E. These activities must be documented and address one or more of the following or other DMH pre-approved topics:

1. Identified methods and approaches commonly used to identify children/youth with behavioral, conduct or emotional disorders;
2. Development of a family action plan;
3. Prevalent treatment modalities;
4. Common medications;
5. Child development;
6. Problem-solving;
7. Effective communication;
8. Identifying and utilizing community resources;
9. Parent/professional collaboration;
10. Overview of a collaborative service network;

11. Consultation and education; and,
12. Pre-evaluation screening for civil commitment for ages fourteen (14) and up.

F. Documentation of the activity and/or group must include, at a minimum:

1. Topic and brief description of the presentation/activity or group
2. Group or individuals to whom the activity was provided
3. Date of activity
4. Number of participants
5. Name and title of presenter(s) or facilitator(s), with brief description of their qualifications/experience in the topic presented.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 39: Making A Plan (MAP) Teams

Rule 39.1 Service Design

A. Making a Plan (MAP) Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders and dually diagnosed with serious emotional/behavioral disorders and an intellectual disability or SED and alcohol/drug abuse; who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

B. Each MAP Team must be comprised of at least one child behavioral health representative employed by the CMHC who has a Bachelor's degree. In addition, there must be at least one representative from each of the following:

   1. Each local school district in a county served by a MAP Team
   2. County Family and Children's Services Division of the State Department of Human Services
   3. County or Regional Youth Services Division of the State Department of Human Services
   4. County or Regional Office of the State Department of Rehabilitation Services
   5. County or Regional Office of the Mississippi State Department of Health
   6. Parent or family member with a child who has experienced an emotional and/or behavioral disturbance
   7. Additional members may be added to each team, to include significant community-level stakeholders with resources that can benefit the children with serious emotional disturbance.

C. The Community Mental Health Center (DMH-C) must maintain a current written interagency agreement with agencies participating in the MAP Team.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 39.2 Access to MAP Teams

A. All providers certified as Community Mental Health Centers (DMH-C) must make available or participate in at least two (2) standing MAP Teams in each CMHC region.

B. All providers certified as DMH/C must have a written plan that describes how each county in their catchment area will develop or have access to a MAP Team. The plan must include time lines for ensuring each county has access to or has developed a MAP Team. Additionally, the plan must be available for DMH Review.

C. Before referring a child/youth to a Psychiatric Residential Treatment Facility (PRTF), the CMHC must first have the local MAP Team review the situation to ensure all available

resources and service options have been utilized. This does not include those children/youth who are in immediate need of acute hospitalization due to suicidal or homicidal ideations.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 40: Respite Care for Children/Youth with an SED

Rule 40.1 Service Design

A. Respite is ~~a~~ short-term planned relief care in the home or community for children/youth with serious emotional/behavioral disturbances or mental health challenges. This service offers time out for caregivers and children/youth, helping family members to cope with their responsibilities, to rest and regroup, facilitate stability, and feel less isolated from the community, family and friends. The provision of services is community-based, culturally competent, and child-centered with the family participating in all decision-making.

B. An individual with, at a minimum, a Master's degree in a mental health or closely related field, must be designated to plan and supervise respite services. The Supervisor can also have administrative or other supervisory responsibility for other services or programs.

C. Providers of Respite Services must maintain documentation of linkages with other health and social service agencies, particularly those that serve children/youth.

D. Respite Services must be available a minimum of once per month for up to the number of hours per month determined necessary, based on individual needs of the child/youth and his or her family.

E. The program must implement behavior management approaches that utilize positive reinforcement of appropriate behaviors. Documentation must be maintained that respite service providers have received all required training for new and/or existing employees/volunteers specified in Part 2: Chapter 12.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 40.2 Policies and Procedures

In addition to the requirements in Part 2: Chapter 8, the written policy and procedure manual for the operation of Respite Services must also include the following areas:

B. Written description of responsibilities of Respite Service providers;

B. Written description of specialized training required for Respite Service providers; and

C. Description of procedures for developing and implementing behavior change/management programs for children/youth served on a regular basis.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 40.3 Information to Parents/Legal Representatives

At the time of the initial interview, the provider of Respite Services must document that the following information has been provided in writing and explained in a manner easily understood to parent(s), legal representative(s) and youth being served in the program, as part of information provided to youth, parent(s)/legal representative(s) prior to or upon provision of Respite Services:

A. Employment criteria/credentials of the potential Respite Service provider;

B. Respite program's policy concerning behavior management. (The program must be very specific in its description pertaining to behavior management.);

C. Signed confidentiality statement; and

D. Service Agreement between the caregiver, the individual staff provider, and the provider agency clearly stating what entity agrees to do while services are being provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 41: Wraparound Facilitation

Rule 41.1 Service Design

A. Wraparound Facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families.

B. Wraparound facilitation is intended to serve:

1. Children/youth with serious mental health challenges who exceed the resources of a single agency or service provider
2. Children/youth who experience multiple acute hospital stays
3. Children/youth who are at risk of out-of-home placement or have been recommended for residential care
4. Children/youth who have had interruptions in the delivery of services across a variety of agencies due to frequent moves
5. Children/youth who have experienced failure to show improvement due to lack of previous coordination by agencies providing care, or reasons unknown can also be served through wraparound facilitation.

C. Child and family team membership must include:

1. The wraparound facilitator;
2. The child's service providers, any involved child serving agency representatives and other formal supports, as appropriate;
3. The caregiver/guardian;
4. Other family or community members serving as informal supports, as appropriate; and
5. Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.

D. The Wraparound family and child team must have access to MAP Team flexible funds if needed for non-traditional supports and resources to carry out the Wraparound Individualized Support Plan.

E. The child/youth accessing funds for non-traditional supports will not need to be reviewed by the MAP Team to access these funds.

F. The Wraparound Facilitator will document expenses in the Plan and the MAP Team Coordinator will include the child/youth in the quarterly reports sent to DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 41.2 Wraparound Activities

A. Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice.

B. Activities include:

1. Engaging the family;
2. Assembling the child and family team;
3. Facilitating a child and family team meeting at a minimum every thirty (30) days;
4. Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting;
5. Working with the team in identifying providers of services and other community resources to meet family and youth needs;
6. Making necessary referrals for youth;
7. Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings;
8. Presenting plan of care for approval by the family and team;
9. Providing copies of the plan of care to the entire team including the youth and family/guardian;
10. Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes;
11. Maintaining communication between all child and family team members;
12. Monitoring the progress toward needs met and whether or not the referral behaviors are decreasing;
13. Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs;
14. Educating new team members about the wraparound process; and
15. Maintaining team cohesiveness.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 42: Peer Support Services

Rule 42.1 Service Design

A. Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery. Peer Support is a helping relationship between peers and/or family members that is directed toward the achievement of specific goals defined by the individual. It may also be provided as a family partner role.

B. Providers of Peer Support Services must develop and implement a service provision plan that addresses the following:

1. The population to be served, including the expected number of individuals to be served, diagnoses, age and any specialization.
2. The types of services and activities offered, particular peer supports utilized, including whether services will be provided on an individual or group basis, type of intervention(s) practiced, typical program day or service and expected outcomes.
3. Program capacity, including staffing patterns, staff to consumer ratios, staff qualifications and cultural composition reflective of population, and plan for deployment of staff to accommodate unplanned staff absences to maintain staff to consumer ratios.
4. A description of how the mental health/substance use disorder professional will maintain clinical oversight of Peer Support Services, which includes ensuring that services and supervision are provided consistently with DMH requirements.
5. A description of how Peer Specialists within the agency will be given opportunities to meet with or otherwise receive support from other Peer Specialists both within and outside the agency.
6. A description of how the Certified Peer Specialist and Certified Peer Specialist Supervisor will participate in and coordinate with treatment teams at the request of a consumer and the procedure for requesting team meetings.
7. A description of how the provider will recruit and retain Certified Peer Support Specialists.

C. Peer Support Services are voluntary. Individuals and/or their guardians must be offered this service when indicated as necessary to promote recovery and resiliency by a mental health professional and/or physician.

D. Peer Support Services are provided one on one (1 on 1) or in groups. When rendered in

groups, the ratio of staff to individuals receiving the service should be, at a minimum, one (1) staff member to eight (8) individuals.

E. Peer Support Services must be included in and coordinated with the individual's Individual Service Plan. A specific planned frequency for service should be identified by the physician and/or mental health professional who believes the individual would benefit from this recovery/resiliency support.

F. Certified Peer Support Specialists must provide documentation of successful completion of at least one of the DMH recognized peer training programs, that is designed to increase the knowledge of the Certified Peer Support Specialist about the population he/she will be supporting.

G. Peer Support Services must be supervised by a mental health professional who has completed the DMH required peer supervisory training.

H. Certified Peer Specialists may be employed as part-time or full-time staff depending on agency capacity, the needs of the community being served, and the preferences of the employee.

I. Providers are encouraged to employ more than one Certified Peer Specialist within an agency and to employ Certified Peer Specialists who reflect the cultural, ethnic, and public mental health service experiences of the people with whom they will work.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 42.2 Activities

A. Peer Support Services include a wide range of structured activities that are provided face to face to assist individuals in their recovery/resiliency process. Activities should support goals of the individual's documented Individual Service Plan and/or Wellness Recovery Action Plan (WRAP) that may include the following:

1. Individual wellness and recovery/resiliency
2. Education and employment
3. Crisis Support
4. Housing and community living
5. Social networking
6. Development of natural supports
7. Self-determination
8. Self-advocacy

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 43: Early Intervention and Child Development Services for Children with a Developmental Delay

Rule 43.1 All Early Intervention and Child Development Services

A. Early Intervention and Child Development Services are designed to support families in providing learning opportunities for their child within the activities, routines, and events of everyday life by providing information, materials, and supports relevant to their identified needs. Early Intervention Services are provided in the child's natural environment. Child Development Services provide center based programs which promote the developmental growth of children in cognitive, physical, social, emotional, communication, and adaptive functioning areas.

B. The program must maintain documentation of at least quarterly public awareness activities that are broad, ongoing, and responsive to rural areas. The program must use a variety of methods to inform the public of available services.

C. The program must conduct and provide documentation of annual Child Find activities in the community to assist in the early identification of children with developmental disabilities or children who are at risk of developing developmental disabilities.

D. Families of children under three (3) years of age must be informed about the First Steps Early Intervention Program (FSEIP) unless they are referred from FSEIP.

E. Within thirty (30) days of admission, a dated photograph of the child must be taken and placed in his/her record. The photo must be updated annually for children birth to three (3) years.

F. Program staff must participate in review, revisions, and annual updates of each child's Individual Family Service Plan (IFSP).

G. The program must have goals and objectives for at least quarterly parental involvement and education which is based on the expressed interests/needs of the parents as ascertained from a parental interest/needs survey.

H. The program must document the provision of information given to parents about developmental disabilities, developmental patterns, and other information pertinent to their child and which is understandable to the parents.

I. The program must assist the family in achieving a smooth transition to educational services or another environment by:

   1. Discussing with parents future services/supports and other matters related to the child's transition to other services/environments;
   2. Supporting the family in preparing the child for changes in service delivery; and

3. Participate in IFSP meetings to discuss transition activities as requested through written prior notice from First Steps.

J. At a minimum, the setting for Early Intervention Services must:

1. Provide equipment that is of an appropriate size and nature for the child using it;
2. Provide materials, toys, and equipment to stimulate, motivate, and entice children to explore the world around them; and
3. Procure special adaptive equipment for children with severe physical disabilities, when required.

K. Program site must maintain and post a current Mississippi State Department of Health inspection as required by law and meet all other applicable local/state/federal laws and regulations.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 43.2 Programs Working with First Steps Early Intervention Programs (FSEIP)

A. Early Intervention Programs must provide services and supports which enhance the family's capacity to support their child's development.

B. The program must document the provision of services and progress toward outcomes as stated on the child's Individualized Family Service Plan (IFSP).

C. Program staff must report to the Service Coordinator in writing the actual day services started within five (5) calendar days after admission into the program.

D. The program must update assessments to determine any changes in the child's skills in the areas of cognition, communication, fine and gross motor, adaptive, and socialization to submit to the FSEIP Service Coordinator for utilization in annual evaluation of the Individualized Family Service Plan.

E. The non-primary service provider must send updated assessment and other needed information to the primary service provider ninety (90) days before the child exits the service. The primary service provider must complete the Outcome Rating Scale within sixty (60) days prior to the child's exit from First Steps Early Intervention.

F. Children must be served in natural environments unless the provision of Early Intervention Services as indicated on the IFSP cannot be achieved satisfactorily in a natural environment.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 43.3 Child Development Services

A. Within thirty (30) days of admission and at least annually thereafter, conduct an educational assessment to determine a child's skills in the areas of cognition, communication, fine and gross motor, adaptive, and socialization for utilization in the development of an individualized service plan.

B. Provide or access services as indicated in a child's evaluation reports from a licensed speech-language pathologist (SLP), qualified teacher, registered occupational therapist (OT), registered physical therapist (PT), and/or other qualified personnel.

C. Document the following in the child's record regarding OT/PT/speech services:

1. Training provided by the OT/PT/speech therapists(s) for program staff
2. Any special techniques needed for the safe handling of a child
3. How program staff might implement any recommended special procedures/techniques into the child's educational program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 44: ID/DD Waiver Support Coordination Services

Rule 44.1 General

A. Support Coordination is responsible for coordinating and monitoring all services an individual on the ID/DD Waiver receives, regardless of funding source, to ensure services are adequate, appropriate, meet individual needs, and ensure the individual's health and welfare needs are met and addressed.

B. The maximum caseload for a support coordinator is thirty two (2) waiver participants.

C. Support Coordinators cannot supervise or provide any other ID/DD Waiver service.

D. Support Coordination Services must be distinctly separate from other ID/DD Waiver service(s) an agency provides.

E. Support Coordinators must adhere to the requirements in the ID/DD Waiver Support Coordination Manual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 44.2 Support Coordination Activities

A. Coordinating and facilitating the development of the Plan of Services and Supports through the person-centered planning process.

B. Revising/updating each individual's Plan of Services and Supports at least annually or when changes in the individual's circumstances occur or when requests are made by the individual/legal guardian.

C. Informing individuals/legal guardians about all ID/DD Waiver, and non-waiver services.

D. Informing individuals/legal guardians about certified providers for the services on his/her approved Plan of Services and Supports initially, annually, if he/she becomes dissatisfied with the current provider, when a new provider/site is certified, or if a provider's certification status is affected.

E. Assisting the individual/legal guardian with meeting/interviewing agency representatives and/or arranging tours of service sites until the individual chooses a provider.

F. Support Coordinators are responsible for entering required information in Medicaid's LTSS System.

G. Notifying each individual of:

1. Initial enrollment
2. Approval/denial of requests for additional services
3. Approval/denial of requests for increases in services
4. Approval for requests for recertification for services
5. Approval for requests for readmission.
6. Reduction in service(s)
7. Termination of service(s)

H. Informing and providing the individual/legal representative with the procedures for appealing the denial, reduction, or termination of ID/DD Waiver services.

I. Educating individuals, legal guardians and families on individual's rights and the procedures for reporting instances of abuse, neglect and exploitation.

J. Performing all necessary functions for the individual's annual recertification of ICF/IID level of care

K. Ongoing monitoring and assessment of the individual's Plan of Services and Supports that must include:

1. Information about the individual's health and welfare, including any changes in health status
2. Information about the individual's satisfaction with current service(s) and provider(s) (ID/DD Waiver and others)
3. Information addressing the need for any new services (ID/DD Waiver and others) based upon expressed needs or concerns or changing circumstances and actions taken to address the need (s)
4. Information addressing whether the amount/frequency of service(s) listed on the approved Plan of Services and Supports remains appropriate
5. Review of Activity Support Plans developed by agencies which provide ID/DD Waiver services to the individual
6. Ensuring all services an individual receives, regardless of funding source, are coordinated to maximize the benefit and outcome for the individual
7. Follow-up activities regarding issues/needs identified during monthly or quarterly contacts or those reported by providers.

L. Monitoring service provision/implementation monthly through onsite face-to-face visits, telephone contacts and review of the monthly utilization.

M. Addressing issues related to an individual's Plan of Services and Supports with his/her provider(s). If a provider is not responsive, the Support Coordinator is responsible for reporting the issue as a grievance through DMH's established grievance reporting procedures through the Office of Consumer Support.

N. Speaking with individuals and/or their legal guardian at least one (1) time~~s~~ per month or more frequently as determined by the Plan of Services and Supports or seeing the individual during a face-to-face contact. The following items must be addressed:

1. Determine if needed supports and services in the Plan of Services and Supports have been provided
2. Review implementation of Activity Support Plans to ensure specified outcomes are being met
3. Review the individual's progress and accomplishments
4. Review the individual's satisfaction with services and providers
5. Identify any changes to the individual's needs, preferences, desired outcomes, or health status
6. Identify the need to change the amount or type of supports and services or to access new waiver or non-waiver services
7. Identify the need to update the Plan of Services and Supports

O. Conducting face-to-face visits with each individual and legal guardian at least once every three (3) months, rotating service settings and talking to staff. For people who receive only day services, at least one (1) visit per year must take place in the person's home.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 45: ID/DD Waiver In-Home Respite Services

Rule 45.1 General

A. In-Home Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home Respite staff provides all the necessary care the usual caregiver would provide during the same time period.

B. In-Home Respite is only available to individuals living in a family home and is not permitted for individuals living independently, either with or without a roommate.

C. In-Home Respite is not available for people who receive Supported Living, Supervised Living, Shared Supported Living, Host Home services, or who live in any other type of staffed residence.

D. In-Home Respite is not available to individuals who are in the hospital, an ICF/IID, nursing home, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance.

E. In-Home Respite cannot be provided in the provider's residence.

F. Staff may accompany individuals on short community outings but this cannot comprise the entirety of the service. Activities are to be based upon the outcomes identified in the PSS and implemented through the Activity Support Plan. Allowable activities include:

1. Assistance with personal care needs such as bathing, dressing, toileting, grooming;
2. Assistance with eating and meal preparation for the person receiving services
3. Assistance with transferring and/or ambulation
4. Administration of medical treatments and/or procedures as prescribed by a physician (In-Home Nursing Respite only)
5. Leisure activities

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 45.2 Family Members as Providers of In-Home Respite

A. The following types of family members are excluded from being providers of In-Home Respite:

1. Anyone who lives in the same home with the individual, regardless of relationship
2. Those that are parents/step-parents of the individual receiving the services
3. Those who are a spouse, relative or anyone else who is normally expected to provide care for the individual receiving the services

B. Providers seeking approval for a family member to serve as In-Home Respite staff, regardless of relationship or qualifications, must maintain the following documentation in each staffs' personnel record in addition to the requirements in Standard 11.2 and Chapter 12:

   1. Proof of address for the family member seeking to provide services. Proof of address is considered to be a copy of a lease, rental agreement, or utility bill that includes that person's name. If required documentation cannot be obtained, the family member seeking to provide services must provide a signed and notarized affidavit that includes his/her current address.
   2. Evidence the individual's ID/DD Waiver Support Coordinator has been notified the agency is seeking approval of a family member to provide HCS.
   3. Family members must receive the same training as non-family members and submit to background checks.

C. Individuals cannot be left unattended at any time during the provision of In-Home Respite Services.

D. Staff providing In-Home Respite cannot accompany individuals to medical appointments.

E. In-Home Respite services cannot be billed for while the person is receiving another Medicaid service, except Behavior Support.

F. Family members providing In Home Respite will only be authorized to provide a maximum of up to 172 hours per month (40 hours per week).

G. Providers must conduct drop-in, unannounced quality assurance visits during the time the approved family member is providing services. These visits must occur at least two (2) times per year. Documentation of these visits must be maintained in the staff's personnel record. Documentation must include:

   1. Observation of the family member's interactions with the person receiving services
   2. Review of the Plan of Services and Supports and Service Notes to determine if outcomes are being met and
   3. Review of utilization to determine if contents of Service Notes support the amount of service provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 45.3 In-Home Nursing Respite</u>

A. The Standards in Rule 45.1 also apply.

B. In-Home Nursing Respite is provided by a registered or licensed practical nurse. He/she

must provide nursing services in accordance with the Mississippi Nursing Practice Act and other applicable laws and regulations.

C. In-Home Nursing Respite is provided for persons who require skilled nursing services, as prescribed by a physician, in the absence of the primary caregiver. The need for administration of medications alone is not a justification for receiving In-Home Nursing Respite services. Caregivers are required to make other arrangements for the administration of medications if they will be absent during the time the medication is normally given.

D. Individuals must have a statement from their physician/nurse practitioner stating:

   1. The treatment(s) and/or procedure(s) the individual needs in order to justify the need for a nurse in the absence of the primary caregiver; and
   2. The amount of time needed to administer the treatment(s)and/or/procedure(s); and
   3. How long the treatment(s) and/or procedure(s) are expected to continues

E. Private Duty Nursing services through EPSDT must be exhausted before waiver services are utilized.

F. In-Home Nursing Respite cannot be provided by family members.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 46: ID/DD Waiver Behavior Support Services

Rule 46.1 General

A. Behavior Support provides systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for individuals whose maladaptive behaviors are significantly disrupting their progress in learning, self-direction or community participation and/or are threatening to require movement to a more restrictive setting. This service also includes consultation and training provided to families and staff working with the individual. The desired outcome of the service is long-term behavior change.

B. If at any time an individual's needs exceed the scope of the services provided through Behavior Support~~s~~, the individual will be referred to other appropriate services to meet his/her needs.

C. This service is not restricted by the age of the individual; however, it may not replace educationally related services provided to individuals when the service is available under EPSDT, IDEA or other sources such as an IFSP through First Steps or ~~be~~ is otherwise available. All other sources must be exhausted before waiver services can be approved. This does not preclude a Behavior Consultant from observing an individual in his/her school setting, but direct intervention cannot be reimbursed when it takes place in a school setting.

D. Behavior Support must be provided on a one (1) staff to one (1) individual ratio.

E. Behavior Support Services consists of:

1. An on-site visit as part of a Functional Behavior Assessment to observe the individual to determine if the development of a Behavior Support Plan is warranted.
2. Informal training of staff and other caregivers regarding basic positive behavior support techniques that could be employed if it is determined that a Behavior Support Plan is not warranted based on the presenting behavior(s).
3. A Functional Behavior Assessment if consultation indicates a need based on the professional judgement of the Behavior Consultant.

F. Functional Behavioral Assessments are limited to every two (2) years, if needed, unless the individual changes providers or the Behavior Support Plan documents substantial changes to:

1. The individual's circumstances (living arrangements, school, caretakers)
2. The individual's skill development
3. Performance of previously established skills
4. Frequency, intensity or types of challenging behaviors

G. A medical evaluation for physical and/or medication issues must be conducted prior to completion of the Functional Behavior Assessment and before a Behavior Support Plan can be implemented.

H. Behavior Support Plans can only be developed by the person who conducted the Functional Behavior Assessment.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 46.2 Role of the Behavior Consultants

A. Behavior Consultants must perform the following activities:

1. Provide consultation as part of the Functional Behavior Assessment
2. Conduct Functional Behavior Assessment
3. Develop Behavior Support Plan
4. Implement the Behavior Support Plan to the degree determined necessary
5. Train the Behavior Specialist and/or staff and other caregivers in the implementation of the Behavior Support Plan.
6. Monitor and review data submitted by the Behavior Specialist to determine progress toward successful implementation of the Behavior Support Plan

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 46.3 Role of the Behavior Specialist

A. Behavior Specialists are responsible for:

1. Participating in the development of the Behavior Support Plan with the Behavior Consultant
2. Implementing the Behavior Support Plan
3. Collecting and analyzing data for the effectiveness of the Behavior Support Plan
4. Monitoring fidelity of implementation of the Behavior Support Plan and reliability of the data
5. Adjusting or revising the strategies identified in the Behavior Support Plan as approved by the Behavior Consultant
6. Providing face-to-face training on the Behavior Support Plan and implementation strategies to staff and other caregivers. This shall include training for meals, hygiene, and/or community activities, and evenings and weekends noted in the behavior support plan as particularly challenging.
7. Monitoring program staff and other caregivers on the implementation of the Behavior Support Plan

8. Submitting documentation to the Behavior Consultant as specified in the Behavior Support Plan which documents progress toward successful implementation of the Behavior Support Plan

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 46.4 Provision of Behavior Support In Conjunction with Other Services

A. All providers must allow for implementation of the Behavior Support Plan in the service setting regardless of if another provider employs the Behavior Support staff. All appropriate staff must receive training from the Behavior Consultant and/or Behavior Intervention Specialist from the Behavior Support provider agency

B. Behavior Support can be provided simultaneously with other waiver services if the purpose is to:

1. Conduct a Functional Behavior Assessment;
2. Provide direct intervention; or
3. Provide training to staff/parents on implementing and maintaining the Behavior Support Plan.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 47: ID/DD Waiver Home and Community Supports (HCS)

Rule 47.1 General

A. Home and Community Supports (HCS) is for individuals who live in the family home and provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) such as bathing, toileting, transferring and ambulation, meal preparation (but not the cost of the meals themselves), assistance with eating and incidental household cleaning and laundry which are essential to the health, safety, and welfare of the individual. Other activities can include assistance with keeping appointments, use of natural supports and other typical community services available to all people, social activities and participation in leisure activities.

B. Home and Community Supports may be shared by up to three (3) individuals who have a common direct service provider agency. Individuals may share HCS staff when agreed to by the participants and the health and welfare can be assured for each participant.

C. Home and Community Supports cannot be provided in a school setting or be used in lieu of school services or other available day services.

D. HCS is not available for individuals who receive Supported Living, Shared Supported Living, Supervised Living, Host Home services, or who live in any other type of staffed residence.

E. HCS is not available to individuals who are in the hospital, an ICF/IID, nursing home, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance.

F. HCS providers are responsible for supervision and monitoring of the individual at all times during service provision whether in the individual's home, during transportation (if provided), and during community outings.

G. Home and Community Supports staff is not permitted to provide medical treatment as defined in the Mississippi Nursing Practice Act and Rules and Regulations.

H. HCS staff cannot accompany a minor on a medical visit without a parent/legal representative present.

I. Home and Community Supports cannot be provided in a provider's home or residence.

J. HCS staff may assist individuals with shopping needs and money management, but may not disburse funds on the part an individual without written authorization from the legal guardian, if applicable.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 47.2 Family Members as Providers of HCS

A. The following types of family members are excluded from being providers of HCS:

   1. Anyone who lives in the same home with the individual, regardless of relationship
   2. Those that are parents/step-parents of the individual receiving the services
   3. Those who are a spouse, relative or anyone else who is normally expected to provide care for the individual receiving the services

B. Providers employing a family member to serve as HCS staff, regardless of relationship or qualifications, must maintain the following documentation in each staffs' personnel record in addition to the requirements in Standard 11.2 and Chapter 12

   1. Proof of address for the family member seeking to provide services. Proof of address is considered to be a copy of a lease, rental agreement, or utility bill that includes that person's name. If required documentation cannot be obtained, the family member seeking to provide services must provide a signed and notarized affidavit that includes his/her current address.
   2. Evidence the individual's ID/DD Waiver Support Coordinator has been notified the agency is seeking approval of a family member to provide HCS.

C. Family members employed as staff to provide HCS must meet the qualifications and training requirements outlined in Part 2: Chapters 11 and 12.

D. Family members providing HCS will only be authorized to provide a maximum of 172 hours per month (40 hours per week).

E. Providers must conduct drop-in, unannounced quality assurance visits during the time the approved family member is providing services. These visits must occur at least two (2) times per year. Documentation of these visits must be maintained in the staff's personnel record. Documentation must include:

   1. Observation of the family member's interactions with the person receiving services
   2. Review of Plan of Services and Supports and Service Notes to determine if outcomes are being met
   3. Review of utilization to determine if contents of Service Notes support the amount of service provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 48 ID/DD Waiver Transition Services

Rule 48.1 General

A. Transition Assistance is a one (1) time set up expense for individuals who transition from institutions (ICF/IID or Title XIX nursing home) to a less restrictive community living arrangement such as a house or apartment where they receive Supervised Living, Shared Supported Living, Supported Living services, or ~~a~~ Host Home Services and who do not use services provided through the Bridge to Independence (Money Follows the Person) program.

B. To be eligible for transition assistance the following is necessary:

   1. The individual cannot have another source to fund or attain the items or support
   2. The individual cannot be transitioning from a setting where these items were provided
   3. The individual must be moving to a residence where these items are not normally furnished.
   4. The individual's ICF/IID or nursing facility stay is not acute or for rehabilitative purposes.

C. Items bought using these funds are for individual use and are to be property of the individual if an individual moves from a residence owned or leased by a provider.

D. There is a one-time, life time maximum of $800 per individual.

E. Service expenditures must be on the individual's approved Plan of Services and Supports.

F. Transition Assistance, if approved on the PSS, must be provided by the community living (Supervised, Shared Supported Living, Supported Living or Host Home) provider in order to aid in transition.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 48.2 Expenditures for Transition Assistance

A. Examples of expenses that may be covered as Transition Assistance are:

   1. Transporting furniture and personal possessions to the new living arrangement
   2. Essential furnishing expenses required to occupy and use a community domicile
   3. Linens and towels
   4. Cleaning supplies
   5. Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent
   6. Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal)

7. Initial stocking of the pantry with basic food items
8. Health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to moving
9. Essential furnishings include items for an individual to establish his or her basic living arrangements such as a bed, table, chairs, window blinds, eating utensils, and food preparation items.

B. Transition Assistance services shall not include monthly rental or mortgage expenses, regular utility charges, and/or household appliances or recreational electronics such as DVD players, game systems, or computers.

C. At the Person Centered Planning meeting, the individual and/or legal guardian, and the rest of the team agree upon the basic types of items to be purchased.

D. The provider makes purchases and arranges to store the item(s) until the individual is ready to move into his/her new home.

E. After the individual moves, the provider submits a claim to Medicaid for the dollar amount of the items, up to the approved maximum reimbursement rate. If the total amount of purchases exceeds the approved maximum reimbursement rate, the provider will only be paid up to that amount.

F. The provider must maintain receipts for all items purchased in the individual's record and send copies to the ID/DD Waiver Support Coordinator.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 49: All Substance Use Disorders Prevention and Treatment Services

Rule 49.1 General

A. All DMH certified service providers of substance use disorders services must submit the Mississippi Substance Abuse Management Information System (MSAMIS) report to the DMH by the tenth (10th) working day of the month following the reporting period.

B. The Provider must have written policies and procedures for the following:

1. Successful completion of treatment
2. Transfer of individual to another program
4. Program re-entry after any disruption of services
5. Individual initiated discharges without completion
   (a) When individuals choose to disregard program rules and regulations after facility has documented all interventions clinically available to staff.
   (b) When individuals willfully choose to leave the program.
6. Staff initiated discharges without completion (last resort):
   (a) Standard protocol of interventions utilized before discharge is initiated.
   (b) The required protocol for treatment team meeting including:
      (1) Required staff present
      (2) Requirement for review of all interventions used prior to this staffing
      (3) How the treatment team makes the discharge decision
      (4) In order to help DMH Referral planning practices
7. Acceptance and accommodation of individuals entering treatment services utilizing medication assisted treatment (MAT)
8. Discharge from services after no therapeutic contact within the last ninety (90) days

C. To assist with appropriate referrals and placement, all residential programs must report to DMH when the census of the program exceeds 90% capacity~~;~~ and When they subsequently fall when the census drops below 90% capacity. Report should be submitted to the Office of Consumer Support by fax or the Bureau of Alcohol and Drug Services by email within 24 hours of crossing the 90% threshold.

D. For programs classified as a state or federal institution or correctional facility that are certified by CARF, The Joint Commission, the American Corrections Association or other certification body approved by the DMH, DMH may accept those certifications in lieu of the Health and Safety Operational Standards with the exception of standards related to clinical program operation and personnel requirements. Programs must be in good standing with the applicable certification body in order for approval to be granted.

E. The Joint Commission (TJC) accredited substance use disorder treatment service providers (not funded by DMH) seeking DMH certification must submit documentation of TJC accreditation in the specific substance use disorder area(s) that corresponds (not to

include DUI) with the substance use disorder service area(s) included in the DMH Operational Standards. The DMH will determine if the documentation is sufficient to support certification in the specific substance use disorder services areas.

F. All programs must have a physical environment which provides designated space for privacy of individual and group counseling sessions.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.2 HIV and Tuberculosis (TB) Risk Assessment and Testing

A. All providers must provide and document that all individuals receiving substance use disorder treatment receive a risk assessment for HIV at the time of intake. For individuals determined to be high risk by the HIV assessment, testing options are determined by level of care and must be provided as follows:

   1. Outpatient Services: Individuals must be offered on-site HIV Rapid testing by the organization or informed of available HIV testing resources available within the community.
   2. Primary Residential Services: Individuals must be offered and encouraged to participate in onsite HIV Rapid Testing. If HIV Rapid Testing is not immediately available, then testing must be offered using other methodology on site or the individual must be transported to a testing site in the community only until such time as a Rapid Testing Program can be implemented.
   3. Transitional Residential and Recovery Support Services: Individuals must be offered and encouraged to participate in onsite HIV Rapid Testing unless the program can provide documentation that the individual received the risk assessment and was offered testing –within the last 6 months. If testing was refused, the facility should encourage further testing. If HIV Rapid Testing is not immediately available, then testing must be offered using other methodology on site or the individual must be transported to a testing site in the community only until such time as a Rapid Testing Program can be implemented.

B. All programs must have and follow written policies and procedures for ensuring maximum participation from individuals in HIV testing to include:

   1. Standardized procedures for conducting an HIV Risk Assessment.
   2. Utilization of an “opt-out” methodology for documenting individuals’ who decline to be tested.
   3. Standardized protocol for explaining the benefits of testing.

C. All programs offering HIV Early Intervention Testing should provide at a minimum:

   1. A minimum of 30 minutes up to one hour of pre-test counseling which must include a risk assessment if one hasn’t been previously conducted.

2. Offer appropriate post-test counseling as needed. If preliminary testing is reactive (positive) then a minimum of 60 minutes of posttest counseling is required.
3. All programs providing onsite testing must have the following

   (a) A Clinical Laboratory Improvements Amendments (CLIA) Waiver
   (b) Relevant Staff training
   (c) A written protocol for HIV testing
   (d) Agreements with the State Department of Health or other relevant agency to obtain HIV test kits, where applicable

D. Programs providing on-site testing must have policies and procedures that include but are not limited to:

   1. Standardized procedures for conducting an HIV test and delivering results
   2. Standardized procedures for obtaining a confirmatory test in the case of a reactive "preliminary positive" test result
   3. Documentation and standardized procedures for providing linkage to care
   4. Quality control procedures to include:
      (a) Proper storage of HIV test kits and controls
      (b) Documentation of when and how often controls are run to verify test accuracy

E. All Primary and Transitional Residential providers must document that all individuals received a risk assessment for Tuberculosis (TB) at the time of intake. Any individual determined to be at high risk cannot be admitted into a treatment program until testing confirms the individual does not have TB.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 49.3 Education Regarding HIV, TB, STDs</u>

A. All providers must provide and document that all individuals receiving substance use disorder treatment services receive a minimum of 1 hour of educational information concerning the following topics in a group and/or individual session:

   1. HIV/AIDS
      (a) Modes of transmission;
      (b) Universal Precautions and other preventative measures against contracting/ spreading the virus; and
      (c) Current treatments and how to access them.
   2. Tuberculosis (TB)
      (a) Modes of transmission; and
      (b) Current treatment resources and how to access them.
   3. Sexually Transmitted Diseases (STDs)
      (a) Modes of transmission;
      (b) Precautions to take against contracting these diseases;

(c) Progression of diseases; and
(d) Current treatment resources and how to access them.

4. Hepatitis
   (a) Modes of transmission;
   (b) Precautions to take against contracting these diseases; and,
   (c) Current treatments and how to access them.

B. Transitional Residential and Recovery Support Services must also provide the services outlined, unless the program can provide documentation that the individual received the educational information prior to a transfer to a less restrictive level of care.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.4 Service to Pregnant Women

A. All substance use disorder programs must document and follow written policies and procedures that ensure:

1. Pregnant women are given top priority for admission;
2. Pregnant women may not be placed on a waiting list. Pregnant women must be admitted into a substance use disorder treatment program within forty-eight (48) hours;
3. If a program is unable to admit a pregnant woman due to being at capacity or any other appropriate reason, the program must assess, refer and assist the individual with placement in another DMH certified program within forty-eight (48) hours;
4. If a program is unable to admit a pregnant woman, the woman must be referred to a local health provider for prenatal care until an appropriate placement is made;
5. If unable to complete the entire process as outlined, DMH Office of Consumer Support must be notified immediately by fax or email using standardized forms provided by DMH. The time frame for notifying DMH of inability to place a pregnant woman cannot exceed forty-eight (48) hours from the initial request for treatment from the individual;
6. If a program is at capacity and a referral must be made, the pregnant woman must be offered an immediate face to face assessment at the agency or another DMH certified provider. If offered at another DMH certified program, the referring provider must fully facilitate the appointment at the alternate DMH certified program. The referring provider must follow up with the certified provider and program to ensure the individual was placed within forty-eight (48) hours.
7. Written documentation of placement or assessment and referral of pregnant women must be maintained onsite and reported to the DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.5 Services to Individuals Who Use IV Drugs

A. All DMH certified substance use disorder programs must document and follow written policies and procedures that ensure:

1. Individuals who use IV drugs are provided priority admission over non-IV drug users.
2. Individuals who use IV drugs are placed in the treatment program identified as the best modality by the assessment within forty-eight (48) hours.
3. If a program is unable to admit an individual who uses IV drugs due to being at capacity or any other appropriate reason, the program must assess, refer and place the individual in another certified DMH program within forty-eight (48) hours.
4. If unable to complete the entire process as outlined in C., DMH Office of Consumer Support must be notified immediately by fax or email using standardized forms provided by DMH. The time frame for notifying DMH of inability to place an individual who uses IV drugs cannot exceed forty-eight (48) hours from the initial request for treatment from the individual.
5. If a program is at capacity and a referral must be made, the referring provider is responsible for assuring the establishment of alternate placement at another certified DMH program within forty-eight (48) hours.
6. The referring provider is responsible for ensuring the individual was placed within forty-eight (48) hours.
7. In the case there is an IV drug user that is unable to be admitted because of insufficient capacity, the following interim services will be provided:
   (a) Counseling and education regarding HIV and TB, the risks of sharing needles, the risk of transmission to sex partners and infants, and the steps to prevent HIV transmission; and
   (b) Referrals for HIV and TB services made when necessary.
8. Written documentation of placement or assessment and referral of IV drug users must be maintained onsite and reported to the DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.6 DUI Convictions

A. Service providers must determine and document, at intake, if the individual has been convicted of more than one DUI that has resulted in a suspended driver's license. If so, the provider must explain the DUI assessment and treatment process to the individual and determine if he/she is interested in participating.

B. Programs must disclose if they are certified by the DMH to conduct DUI assessments.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 50: Withdrawal Management Services

Rule 50.1 General

A. The Withdrawal Management standards in this section are based on the *American Society of Addiction Medicine*© established criteria for Level 3.2-WM: Clinically Managed Residential Withdrawal Management (sometimes referred to as "social detox") and 3.7 Medically Monitored Inpatient Withdrawal Management.

B. These services must be provided in conjunction with the DMH certified Primary Residential services.

C. All programs must utilize the results of a medical screening instrument(s) identifying the need for Withdrawal Management Services. The screening assessments should be conducted as often as the individual case warrants.

D. Programs providing Withdrawal Management Services must have written policies and procedures which specify the following:

1. An individual designated as responsible for coordinating Withdrawal Management Services;
2. A description of the method by which Withdrawal management Services are offered; and
3. A description of the method by which referrals are made to physicians and/or hospitals for appropriate medical intervention.
4. Criteria for admission, care, discharge, and transfer of a client to another level of care.

E. All Residential Programs must have a current contract on file with a Medically Managed Intensive Inpatient Withdrawal Management Provider. If applicable and funds are available The DMH will reimburse this contract for individuals experiencing physical withdrawals from benzodiazepines, and/or alcohol, individuals using opiates in combination with benzodiazepines and/or alcohol or individuals who have a history of a biomedical condition(s) that will complicate withdrawal. If the program is serving pregnant females, the following must be include:

1. The contract with the medical provider will state that women will not be detoxed during pregnancy without consideration by a physician or nurse practitioner of the impact it would have on the mother or her fetus.
2. All Residential Programs are responsible for ensuring that pregnant women are evaluated immediately by a physician, hospital, or medical clinic when symptoms of intoxication, impairment, or withdrawal are evident.
3. All Residential Programs must provide transportation for pregnant women that are referred to a physician, hospital, medical clinic or other appropriate Residential Facility.

4. Withdrawal management services for pregnant/prenatal women will take into account up-to-date medical research.

F. Programs should establish a protocol for immediate referral to an acute care facility such as:

1. The proper threshold score as established by the assessment instrument
2. When the individual has any one of the following:
   (a) Seizures or history of seizures;
   (b) Current persistent vomiting or vomiting of blood;
   (c) current ingestion of vomit in lungs;
   (d) clouded sensorium such as gross disorientation or hallucination;
   (e) a temperature higher that one hundred and one degrees Fahrenheit;
   (f) abnormal respiration such a shortness of breath or a respiration rate greater than twenty-six (26) breaths per minute;
   (g) elevated pulse such as a heart rate greater than one hundred (100) beats per minute or arrhythmia;
   (h) hypertension such as blood pressure greater than one hundred sixty (160) over one hundred twenty (120);
   (i) sudden chest pain or other sign of coronary distress or severe abdominal pain;
   (j) unconscious and not able to be awakened; ~~or~~
   (k) other signs of significant illness such as jaundice, unstable diabetes, acute liver disease, severe allergic reaction, poisoning, progressively worsening tremors, chills, severe agitation, exposure, internal bleeding shock
   (l) uncontrollable violence,
   (m) suicidal or homicidal ideations.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 50.2 Staffing and Observation</u>

A. Programs providing Level 3.2-WM: Clinically Managed Residential Withdrawal Management Services must provide a level of services designed to safely assist individuals through withdrawal without the need for onsite medical and nursing personnel. Services must contain the following:

1. Appropriately credentialed personnel who are trained to provide physician approved protocols, and recognize signs and symptoms of alcohol and drug intoxication, withdrawal and appropriate monitoring of those conditions. Staff must:
   (a) Observe and supervise the individual
   (b) Determine the individuals appropriate level of care
   (c) Facilitate the individuals transition to continuing care
2. Twenty-four (24) hour a day medical evaluation and consultation.
3. A written agreement or contract with a local hospital able to provide Medically Managed Withdrawal Management Services as defined by ASAM.

4. Staff supervision self-administered medications must be appropriately licensed or credentialed by the state of Mississippi.

B. Programs providing Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management Services. This service provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require twenty-four (24) care delivered by medical and nursing professionals. Services must include the following:

1. Program staffed by a physician or appropriately licensed staff performing the duties as a physician under a collaborative agreement or other requirements of the medical practice act.
2. Physician or licensed designee must be available twenty-four (24) a day by telephone.
3. Individual must be assessed by a physician or licensed designee within twenty-four (24) of admission or earlier if medically necessary.
4. A registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission.
5. Documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the withdrawal management Programs providing this service must have a written plan describing the handling of medical emergencies which includes the roles of staff members and physicians.
6. Must have interdisciplinary team of appropriately trained staff available to assess and treat the individual's needs.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 51: Substance Use Disorder Recovery Support Services

Rule 51.1 General

A. Recovery Support Services are non-clinical services that are offered before, during and after any services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of social, legal, and other resources that facilitate recovery and wellness to reduce or eliminate environmental or personal barriers to recovery. RSS include social supports, linkage to and coordination among allied service providers, and other resources to improve quality of life for people in and seeking recovery and their families.

B. The Recovery Support staff must maintain on site a comprehensive file of existing community resources. Each listed resource must include:

   1. The name, location, telephone number and hours of operation of the resource;
   2. The types of services provided by the resource;
   3. Eligibility requirements; and
   4. Contact person(s).

C. Recovery Support Staff must develop an annual plan for conducting community outreach activities that must include:

   1. Each county in their catchment area
   2. An emphasis on alcohol and other drug treatment and prevention services offered by their organization
   3. A minimum of twelve (12) community activities per year and cannot be limited to exhibits or booths at community events
   4. Identification of targeted community health providers, areas or populations such as workplaces of young adults, physicians, drug courts, etc.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 51.2 Availability of Recovery Support Services

Recovery Support Services must be provided to individuals regardless of where or if Primary Treatment Services have been completed.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 51.3 Policies and Procedures

A. Recovery Support Services must establish a written policy which details a twelve (12) month step down approach for the delivery of Recovery Support Services. Emphasis must be placed on the "critical time" of the first six (6) months of service.

B. The highest level of frequency of contacts during the first one to three (1-3) months must include, at a minimum:

   1. Face to face contact for a minimum of one hour weekly (more if determined to be necessary). This may be in the form of non-clinical psychoeducational groups, individual support, or family support sessions.
   2. Community involvement is required. This may be in the form of 12 step meeting (s), volunteerism, faith based support groups or any other mutually agreed upon meaningful pro-social activity that supports recovery.
   3. Weekly random drug screen
   4. Weekly family contact is required. If individual/family refuses to participate documentation is required.

C. The subsequent three (3) months must include, at a minimum:

   1. Face to face contact for a minimum of one hour every other week (more if determined to be necessary). This may be in the form of non-clinical psychoeducational groups, individual support sessions, or family support sessions.
   2. Continued Community involvement is required. This may be in the form of 12 step meeting (s), volunteerism, faith based support groups or any other mutually agreed upon meaningful pro-social activity that supports recovery.
   3. Monthly random drug screens; and
   4. Family contact as needed. If individual/family refused contact in the prior three months, it must be re-addressed and documentation is required.

D. The remaining six (6) months should be determined following outcomes of the first six (6) months.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 51.4 Contacts

A. For the six (6) months immediately following completion of treatment, as described in Rule 55.2, Recovery Support staff must make at least one (1) attempt to contact each member per month. Group or individual sessions are acceptable as contacts.

B. Recovery Support Staff should attempt to contact individuals immediately, but not to exceed forty-eight (48) business hours, following a missed appointment.

C. Following a missed appointment, Recovery Support Staff must make at least three (3) separate attempts to contact each individual on their caseload prior to discharging the individual. A record of contacts/attempts must be maintained in the individual's record. Contact must include the most appropriate means of engagement preferred by the individual to encourage continued participation such as phone calls, face to face visits, letters, emails or other electronic technology as long as full confidentiality is maintained.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 52: Substance Use Disorder Prevention Services

Rule 52.1 General

A. Prevention Services are designed to reduce the risk factors and increase the protective factors linked to substance use disorder and related problem behaviors to provide immediate and long-term positive results. The process begins prior to the onset of a disorder. These interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, tobacco use, and illicit drug use.

B. No Prevention Services will be provided to persons who are actively engaged in any substance use and addictive disorders program. This includes individuals detained in a facility for drug related offenses.

C. All prevention programs must implement at least three (3) of the following six (6) strategies, required by the Center for Substance Abuse Prevention (CSAP) in the delivery of Prevention Services:

   1. Information/dissemination
   2. Affective education programs
   3. Alternative programs
   4. Problem/Identification and referral
   5. Community-based process (Community development)
   6. Environmental programs.

D. All DMH certified providers of Prevention Services must document all prevention activities on the designated Internet-based tool or other required tool by the tenth (10th) working day of the month following the reporting period.

E. All prevention providers must have a staff member designated to coordinate the prevention program.

F. Individuals working in prevention services must have their own working computer (provided by the certified provider) with internet access.

G. All prevention programs must show evidence of ongoing use of at least one (1) model, evidence-based curriculum recommended by the Center for Substance Abuse Prevention (CSAP). All programs are required to provide an evidenced-based curriculum schedule upon request. The percentage of evidence-based curriculum implementation must adhere to BADS grant requirements.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 53: DUI Diagnostic Assessment Services for Second and Subsequent Offenders

Rule 53.1General

A. The DUI Diagnostic Assessment is a process by which a diagnostic assessment (such as, Substance Abuse Subtle Screening Inventory (SASSI), or other DMH approved tool) is administered and the result is combined with other required information to determine the offenders appropriate treatment environment.

B. All DMH certified programs which conduct DUI Assessments must have a designated staff member(s) responsible, accountable, and trained to administer the assessment and implement the program procedures.

C. The program must have written policies and procedures and adhere to those policies and procedures which describe:

   1. The criteria by which the treatment environment is determined
   2. The criteria by which successful completion of treatment is determined for DUI offenders
   3. The process by which an individual is admitted into a substance use disorder treatment program following completion of the DUI Diagnostic Assessment.

D. The DUI Diagnostic Assessment must consist of the following components and be documented in the individual's case file:

   1. Motor Vehicle Report from an official governmental source such as the MS Department of Public Safety.
   2. Results and interpretation of the SASSI, or other DMH Bureau of Alcohol and Drug Abuse approved tool. In order to administer the diagnostic tool, at least (1) one staff member must be certified.
   3. An Initial Assessment.

E. Individuals receiving DUI treatment services through a DUI Outpatient Program must receive a minimum of twenty (20) hours of direct service (individual and/or group therapy), in no less than ten (10) separate therapeutic sessions or as otherwise specified by the DMH BADS, before receiving the DMH Certification of DUI In-Depth Diagnostic Assessment and Treatment Form. Documentation of treatment will be maintained in the individual's record.

F. All DUI Diagnostic Assessment/Treatment Programs must submit the DMH Certification of DUI In-Depth Diagnostic Assessment and Treatment Form and a release of information to the BADS when an individual has successfully completed the treatment program.

G. All DUI Diagnostic Assessment services must be equipped to provide each individual the type of substance use disorder treatment indicated by the results and interpretation of the assessment (components listed in this section above). Substance use disorder treatment may be offered through the assessment service and/or through an affiliation agreement with a DMH certified substance use disorder treatment program. The assessment service must be able to provide, at a minimum, outpatient and primary residential or inpatient chemical dependency substance use disorder treatment.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 54: Opioid Treatment Services

Rule 54.1 General Related to Opioid Treatment Programs

A. The Mississippi Department of Mental Health (DMH), Bureau of Alcohol and Drug Services (BADS), will serve as the State Authority for Opioid Treatment Programs under the authority provided under state statute (Section 41-4-7 of the Mississippi Code of 1972, Annotated). Such programs shall provide withdrawal management services to people suffering from chronic addiction to opiates/opiate derivatives. The services support the individual by utilizing methadone, and/or Buprenorphine while the individual participates in a spectrum of counseling and other recovery support services directed toward that are intended to assist the person with successful recovery from opiate addiction.

B. Providers of Opioid Treatment Programs (OTP) shall comply with all applicable federal, State, and local laws, codes, and/or rules to include, but not be limited to, those promulgated/administered by or through the United States Department of Health and Human Services (DHHS), SAMHSA, Drug Enforcement Administration (DEA) regulations, and the Controlled Substances Act (21 U.S.C. 823 (g) (l).

C. An Opioid Treatment Program must have a current, valid certification from SAMHSA and permanently display proof of that current certification in public view, available for public inspection. Additionally, Opioid Treatment Programs must have a current certification from the Commission on Accreditation of Rehabilitation Facilities (CARF).

D. The operation of each Opioid Treatment Program must be in compliance with the Mississippi Pharmacy Practice Act (Section 73-21-69 et. seq. of the Mississippi Code as Annotated, 1972) as well as current rules and regulations promulgated by the State Board of Pharmacy; and must at a minimum obtain and maintain a "Pharmacy Permit," as defined and authorized by the Mississippi Board of Pharmacy.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.2 Staffing for Opioid Treatment Programs

A. An Opioid Treatment Program must employ sufficient and qualified staff to meet the treatment and support needs of the population served. Services must be provided by an interdisciplinary team, all of whom are properly licensed, registered, or certified by the appropriate authority in accordance with Mississippi law. At a minimum, the staff must include:

1. A licensed physician;
2. A Registered Nurse;

3. A Licensed pharmacist, and
4. Licensed psychologist/counselor/social worker, licensed/certified mental health therapist (specialized in substance use and disorders services) who must be on-site during all hours of operation. The therapist to individual ratio must be set with a limited caseload that supports and meets the needs of the individuals receiving services and limits must be addressed in the agency's policies and procedures.

B. An Opioid Treatment Program must designate a medical director/staff physician who is responsible for administering and supervising all medical services performed by the program. The medical director/staff physician must be a physician licensed in the State of Mississippi. He/she must be on site as needed to complete all medical needs in accordance with standard medical practice and available by phone as needed.

C. An Opioid Treatment Program must employ at least one full-time Registered Nurse (RN) for the first 100 or fewer individuals. In addition to the one full-time registered nurse additional registered nurses must be maintained so as to provide nursing services at least one (1) hour per week per five (5) individuals enrolled over 100 individuals. (For example a program serving 150 individuals would have one full-time RN and an additional ten (10) hours per week of RN time from another RN on staff). Nursing functions may be supplemented by a licensed practical nurse, if a registered nurse or physician is on-duty. All nursing services provided must be in compliance with the Mississippi Nursing Practice Act (Section 73-15-1 et. seq. of the Mississippi Code of 1972 as Annotated) and current rules and regulations promulgated by the Mississippi State Board of Nursing.

D. A person may hold more than one staff position within the facility if that person is qualified to function in both capacities, and the required hours for each job are separate and apart for each position.

E. All Opioid Treatment Programs must provide availability of staff seven (7) days a week, twenty-four (24) hours a day. A record of the on-call schedule must be maintained and the individuals must be informed of how to access the on-call staff; therefore, a signed statement by the individual must be maintained in the individual's record. The on-call staff must be available at all times for emergencies of the individuals served. The on-call staff must have access to pertinent individual information including dosage levels.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 54.3 Admissions to Opioid Treatment Programs</u>

A. The Opioid Treatment Program must have written policies and procedures to describe the total process for admission to the program and must at a minimum include:

1. A face-to-face with each person requesting methadone maintenance treatment services;
2. Documentation and identification of the individual's immediate/urgent need (s);
3. Admission criteria must include, but not be limited to the following:

   (a) Current diagnosis of opioid dependence in accordance with the Diagnostic and Statistical Manual of Mental Disorders (Current Edition).
   (b) Individual is at least 18 years old; as evidenced by:
      (1) Driver's license; or
      (2) Birth certificate or Social Security card;
   (c) Individual meets the federal requirements, including exceptions, regarding determination that individual is currently addicted to opiates and has been addicted to opiates for at least one (1) year prior to admission;
   (d) Individual is not currently enrolled in another Opioid Treatment Program;
   (e) Individual has signed a statement to evidence his/her understanding of the risks and side effects;
   (f) Individual has signed a statement to evidence his/her understanding of the options concerning all treatment procedure in Opioid Replacement Management;
   (g) Individual has signed a statement evidencing that admission is voluntary;
   (h) Individual has been informed of and received a copy of rights of individuals served by the program, including confidentiality (a signed copy must be maintained in the individual's record);
   (i) Individual has been informed of and received a copy of program rules (signed documentation of receipt of program rules must be maintained in the individual's case record)
   (j) Individual has received counseling, testing, and education regarding HIV, Hepatitis B, Hepatitis C, tuberculosis, and sexually transmitted diseases (documentation must be maintained in the individual's record); and
   (k) Individual must have signed documentation that they understand the fee schedule and tapering process due to inability to pay for services.
4. Criteria for waiting list (a plan must be documented);
5. Any specific conditions/situations that would exclude an individual from being eligible for admission. Provisions for and documentation of recommendations for alternate services must be included.

B. Each individual must be provided an orientation prior to administration of any medication. The orientation must be documented by a signed statement that is maintained in the case record which proves the individual acknowledges receipt of a program handbook. The program handbook must include, but is not limited to the following:

1. Signs and symptoms of overdose, and conditions for seeking emergency assistance;
2. Description of the medications to be administered by the program, including potential risks, benefits, side effects, and drug interactions;
3. The nature of addictive disorders;
4. The goals and benefits of medication-assisted treatment and the process of recovery;
5. Voluntary and involuntary discharge procedures;
6. Toxicology (UDS) testing procedures;
7. Medication dispensing procedures;
8. Hours of operations;
9. Medication fee schedule; and
10. Counseling services offered during treatment.

C. Each individual must be reviewed prior to admission and annually thereafter from the date of admission on the Prescription Drug Monitoring Program (PDMP) in MS and nearby states for which access is available to assess for appropriateness of Opioid Treatment Services. No individual is eligible for admission or continued services/treatment whose review indicates the potential for diversion. Each PDMP access shall confirm the individual is not seeking prescription medication from multiple sources. The program shall access the PDMP:

1. Upon admission;
2. Before initial administration of methadone or other treatment in a opioid treatment program;
3. Prior to requesting any Take-Home dosing exceptions and shall submit the resulting report to the State Opioid Treatment Authority (SOTA) with the exception request;
4. After any positive drug test for prescription medication; and
5. Every six months to determine if controlled substances other than methadone are being prescribed for the individual. The individual's record shall include documentation of the results of the PDMP database check and the date upon which it occurred.

D. No Program shall provide any form of consideration, including but not limited to free or discounted services or medication, for referral of potential clients to the Program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 54.4 Opioid Treatment Program Services</u>

A. Medical Services must be provided by the Medical Director of the program. The Medical Director must:

1. Be a physician licensed under Mississippi law who has been designated to oversee all medical services of a provider and has been given the authority and responsibility for medical care delivered by a provider. This includes ensuring the program is in

compliance with all federal, state, and local laws and regulations regarding the medical treatment of addiction to an Opioid drug.

2. Be ASAM certified; have documented references in working experience in an opioid treatment program and have documented education in addiction services.
3. Be available to the program on a continual basis, seven (7) days per week, twenty-four (24) hours per day.
4. Be present or ensure that qualified medical personnel are present in the program location for two (2) hours per week for each fifty (50) clients enrolled.
5. Complete a full physical and biopsychosocial evaluation for each client annually to re-confirm for the need for the continued participation in the OTP.
6. Ensure that a Pharmacist licensed by the state of Mississippi is present and overseeing the dispensing of medication at each program location.

B. Program Services much include, but are not limited to, the following:

1. Medical Services under the direction of the Medical Provider will include an initial history and physical evaluation to determine diagnosis and if the individual meets criteria for methadone maintenance treatment (MMT); unless the individual can provide documentation of a medical examination (including laboratory test results) that was conducted within fourteen (14) days prior to admission. The physical evaluation will include but not be limited to the following:
   (a) A complete medical history;
   (b) Baseline toxicology report produced from a urine drug screen (UDS) that includes at a minimum testing for the following substances using the following cutoff concentrations:
      (1) Opiates 100 ng/ml;
      (2) Methadone 300 ng/ml;
      (3) Benzodiazepines 200 ng/ml;
      (4) Barbiturates 200 ng/ml;
      (5) Cocaine 300 ng/ml;
      (6) Amphetamines 1000 ng/ml;
      (7) Tetrahydrocannabinol 100 ng/ml;
      (8) Alcohol .03 gm/dl;
      (9) Any other drug known to be frequently used in the locality of the OTP.
   (c) A tuberculosis (TB) skin test or chest x-ray if the skin was ever previously positive;
   (d) Screening for STDs;
   (e) Other laboratory tests as clinically indicated by the client's history and physical examination; and
   (f) A pregnancy test shall be completed, and the results documented, for each female of childbearing potential prior to the initiation of Opioid treatment, medically-assisted withdrawal, or detoxification procedures.
2. Provide for the medical needs (annual physical exams, prescribing of medications, follow up evaluations, ordering and review of lab work), of the individuals being served in accordance with current standards of medical practice;

3. Ensure that the program is in compliance with local, state, and federal guidelines as they relate to the medical treatment of opioid addiction;
4. Determine the adequate treatment dose of methadone to meet the needs of the person served;
5. Provide for dosing and counseling services seven (7) days each week;
6. Establish hours of operations that are flexible to accommodate the majority of client school, work, and family responsibility schedules;
7. Maintain physical plant that is adequate in size to accommodate the proposed number of clients, required program activities, and provide a safe, therapeutic environment that supports enhancement of each client's well-being and affords protection of privacy and confidentiality;
8. Reconcile administration and dispensing medication inventory;
9. Approve all take-home medications; and
10. Participate in treatment planning including approval and signing of all plans.

C. Nursing Services provided must be in compliance with the Mississippi Nursing Practice Act (Section 73-15-1 et. seq. of the Mississippi Code of 1972 as Annotated) and current rules and regulations promulgated by the Mississippi State Board of Nursing. These duties and responsibilities are in addition to requirements of the Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers and must include the following:

1. Administration of all methadone medication as prescribed by the licensed Medical Director/physician;
2. Documentation of all medication administered and countersigning of all changes in dosage schedule;
3. Provision of general nursing care in addition to alcohol and drug services when ordered by the program's licensed medical director Medical Director/ physician;
4. Supervision of functions that may be supplemented by a licensed practical nurse; and
5. Participation in treatment team meetings.

D. Counseling and Recovery Support Services are a part of a holistic approach to treating the opiate addicted individual. Counseling services must be provided by a licensed psychologist, licensed professional counselor, licensed certified social worker or DMH credentialed addictions therapist and must be provided in accordance with the following requirements:

1. Written documentation must support decisions of the treatment team including indicators such as a positive drug screens, inappropriate behavior, criminal activity, and withdrawal management procedures.
2. Counseling must be provided individually or in small (not to exceed 12 individuals) groups of individuals with similar treatment needs.

3. Each individual must be assigned to a primary counselor and the counselor must be familiar with all individuals on his/her caseload and document all contacts in the individual's record.
4. Specialized information and counseling approaches for individuals who have special problems, i.e., terminal illness must be provided and documented;
5. Counselors must assess the psychological and sociological backgrounds of individuals, contribute to the treatment team, and monitor individual treatment programs.
6. Counselor to individual ratio cannot exceed 1:~~75~~40 (one counselor to every forty (40) individuals served by the program).

E. Through the provision of Counseling Services, therapeutic interventions must be available as needed but at a minimum of the following:

1. Evidence-based therapeutic programs/practices, stress/anxiety management and relapse prevention must be included as a schedule of therapeutic interventions.
2. Individual, group or family therapy sessions must be provided for one (1) hour per week for the first ninety (90) days of treatment.
3. Individual, group, or family therapy sessions must be provided for two (2) hours per month for days ninety-one (91) through one hundred eighty (180) of treatment.
4. Individual, group or family therapy sessions must be provided for one (1) hour per month for the remainder of treatment.
5. Provide referrals for special needs.
6. Provide focused counseling in cases of psychosocial stressors such as:
   (a) Abuse/neglect (known or suspected);
   (b) Marital (relationship);
   (c) Pregnancy;
   (d) Financial/legal;
   (e) Vocational/educational;
   (f) Infectious disease; and/or
   (g) Other services as ordered/indicated.

F. Women's Services must be provided to ensure accessibility of services to pregnant women. The program must develop, maintain, and document implementation of written policies and procedures to ensure the provision and accessibility of adequate services for women. The program must governed by but is not limited to the following which must be documented in the client record:

1. Give priority to pregnant women in its admission policy;
   (a) Cannot deny admission solely on the basis of the pregnancy;
   (b) If a program is unable to provide services for a pregnant women, the State Opioid Treatment Authority much be notified as to how the program will assist the pregnant women in locating services;

2. Arrange for and document medical care during pregnancy by appropriate referral, and written and recorded verification that the individual receives prenatal care as planned;
3. Implement informed consent procedures for individuals who refuse prenatal care to ensure the individual acknowledges in writing that she was offered prenatal treatment but refused;
4. Ensure that the pregnant individual is fully informed of the possible risks to her unborn child from continued use of illicit drugs or from a narcotic drug administered during maintenance or withdrawal management treatment;
5. Ensure that the pregnant individual is fully informed of the possible risks and benefits to her unborn child from participating in the OTP;
6. Document implementation of the process to provide pregnant clients with access to or referral for prenatal care, pregnancy/parenting education, and postpartum follow-up.
7. Obtain written consent to reciprocally share client information with existing medical provider or future medical providers that has been or will be treating the pregnant women
8. For pregnant women who refuse appropriate referral for prenatal services, the program shall:
   (a) Utilize informed consent procedures to have the client formally acknowledge, in writing, that the OTP offered a referral to prenatal services that was refused by the client;
   (b) Provide the client with the basic prenatal instruction on maternal, physical, and dietary care as part of the OTP counseling services and document service delivery in the clinical record;
9. Provide written documentation of implementation for the following procedures to care for pregnant women:
   (a) Clients who become pregnant during treatment shall be maintained on the pre-pregnancy dosage, if effective, as determined by the Medical Director;
   (b) Dosing strategies will be consistent with those used for non-pregnant clients unless otherwise indicated;
   (c) Methadone dose shall be monitored more intensely during the third (3) trimester;
10. The program shall document in writing and file in the clinical record the decision by and process utilized for a pregnant woman who elects to withdraw from methadone with documentation to include the following minimum requirements.
    (a) The Medical Director shall supervise the withdrawal process.
    (b) Regular fetal assessments, as appropriate for gestational age, shall be part of the withdrawal process.
    (c) Education shall be provided on medically supervised withdrawal and the impact of medically supervised withdrawal services on the health and welfare of unborn children.
    (d) Withdrawal procedures shall adhere to accepted medical standards regarding adequate dosing strategies.

(e) When providing medically supervised withdrawal services to pregnant women who withdrawal symptoms cannot be eliminated, referrals to inpatient program shall be made.
(f) The program shall describe in writing and document implementation of policies and procedures, including informed consent, to ensure appropriate post-pregnancy follow-up and primary care for the new mother and well-baby care for the infant.

11. Maintain documentation of an annual review by the Medical Director of the protocol for treating pregnant females.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.5 Medication Management for Opioid Treatment Programs

A. The medication used in the treatment of opiate addiction must at a minimum:

1. Be approved by the Food and Drug Administration (FDA);
2. Be administered only as authorized and directed by orders signed by the medical director;
3. Be dispensed according to product pharmaceutical label; and
4. Be appropriate to produce the desired response for the desired length of time.

B. Urine drug screening (UDS) must be included as one source of information in making programmatic decisions, monitoring drug use, and making decisions regarding individual's capability to receive take-home medication. They must NOT be used as the sole criterion to discharge a client from treatment.

C. The Program must include methodology for conducting a urine drug screening in its policies and procedures that at a minimum, ensures the following:

1. Urine specimens are obtained in a treatment atmosphere of trust and safety, rather than of punishment and power;
2. Results of all drug testing shall be filed in the client's clinical record;
3. Urine testing shall be documented and performed by a laboratory certified by an independent, federally approved accreditation entity;
4. Specimen testing includes the same panel and cutoff concentrations as the baseline toxicology report;
5. Specimens are obtained randomly on the basis of the individual clinic visit schedule; but no less than twice a month for the first thirty (30) day and a minimum of eight (8) times in any twelve (12) month period.
6. Individuals have signed a statement that he/she has been informed about how urine specimens are collected and of the responsibility to provide a specimen when asked (a signed statement must be maintained in the individual's record);

7. The bathroom used for collection is clean and always supplied with soap and toilet articles;
8. That specimens are collected in a manner that minimizes falsification; if using direct observation, the procedures must be carried out ethically and professionally.
9. That results of urine screens are communicated promptly to individual to facilitate rapid intervention with any drug that was disclosed or with possible diversion of methadone as evidenced by lack of methadone or its metabolites in the urine; and,
10. The program will develop a specific, DMH approved policy, requiring that blood serum testing will be done on an individual if there is any reason for suspicion that the urine testing is incorrect or in any manner thought to be false. This policy must be developed and approved prior to opening the program.

D. The program must have written policies and procedures that outline the documentation and implementation of standard procedures for addressing a Failed Urine Drug Screen, which is defined as positive toxicology results for illicit drugs and/or negative results for drugs provided by the OTP in the course of opioid maintenance therapy. These policies and procedures must include, but are not limited to the following:

1. Baseline toxicology testing results shall be discussed with the client and documentation of this discussion recorded as a progress note in the clinical record;
2. For new clients who are within the first ninety (90) days of treatment, a failed urine drug screen will be discussed by the counselor and the client during the next clinic visit to review the treatment plan and modify services as needed.
3. For clients with take-home privileges:
   (a) The first failed urine drug test will result in the following:
      (1) Client will be placed on probation for ninety (90) days;
      (2) Client will receive a minimum of two (2) random drug screens per month during the probationary period; and
      (3) Client must be required to meet with his/her primary counselor to discuss toxicology results and individual service plan.
   (b) The second failed urine drug test will result in the following:
      (1) Client will be transferred to a lower dosing phase;
      (2) Client will receive a minimum of two (2) random drug screens per month during the probationary period; and
      (3) Client must be required to participate in a clinical staffing with the treatment team to develop and implement a remedial plan.
   (c) The third and subsequent failed urine drug test will result in the following:
      (1) Complete biopsychosocial re-assessment;
      (2) Complete medical re-evaluation of medication dosage, plasma levels, metabolic responses and adjustment of dosage;
      (3) Assessment for co-occurring disorders and modifications to treatment protocol as needed;
      (4) Increase in counseling services, change in primary counselor and/or family intervention as appropriate; and

(5) Consideration of alternative opioid addiction treatment.

(d) The sixth consecutive failed urine drug test will result in the client being informed that administrative withdrawal procedures will begin immediately and a referral made to the appropriate level of care unless the Medical Director:

(1) Provides objective clinical contraindications of the need for this action; and

(2) Develops a written intervention plan in consultation with the client and the treatment team to detoxify from any substance not prescribed by the OTP, and intensify counseling.

E. When dispensing Methadone the program must:

1. Ensure that each medication administration and dosage change is ordered and signed by the program Medical Director;
2. Ensure that administration of each dose is documented in the individual's record;
3. Ensure that administration of each dose is documented in the medication sheets;
4. Document administration of the dose with signature or initials of the qualified person administering the medication; and
5. Document the exact number of milligrams of the medication dispensed with daily totals.

F. The initial dose of methadone should be prescribed by the Medical Director based on standard medical practice and sound clinical judgment. The initial total daily dose for the first day may not exceed 30 mg unless the Medical Director documents in the individual's record that 30 mg did not suppress opiate abstinence symptoms.

G. Subsequent doses of medication shall be:

1. Individually determined based upon the Medical Director's evaluation of the history and present condition of the client.
2. Reviewed and updated as according to the client's treatment plan and in consideration of the following criteria:

(a) Cessation of withdrawal symptoms

(b) Cessation of illicit opioid use as measured by:

1. Negative drug tests; and
2. Reduction of drug-seeking behavior

(c) Establishment of a blockade dose of an agonist

(d) Absence of problematic craving as measured by:

1. Subjective reports; and
2. Clinical observations

(e) Absence of signs and symptoms of too large an agonist dose after an interval adequate for the client to develop complete tolerance to the blocking dose

3. Subject to a process which shall be established by the Program to address individuals who are objectively intoxicated or who are experiencing other problems that would render the administration of methadone unsafe.

H. The Program shall have a written policy for Split Dosing that must:
   1. Include input from the Medical Director in consultation with the treatment team and the SOTA;
   2. Accurately reflect that split dosing is guided by outcome criteria that shall include:
      (a) The client complains that the dosage level is not holding.
      (b) The client exhibits signs and symptoms of withdrawal.
      (c) The Medical Director employs peak and trough criteria for split dosing, if appropriate.
      (d) The Medical Director is unable to obtain a peak and trough ratio for 2.0 or lower, increasing intervals of dosing may be appropriate.
      (e) Addressing the failure of all avenues of stabilization
      (f) Addressing stabilization failures with the client involving the Medical Director and treatment team
   3. Include provisions for education of the client on the rationale for split dosing and Take-Home medication.

I. The Program shall develop, maintain, and document implementation of dosing policies and procedures for the provision of medication to a guest client "Guest Dosing" in a program in which the client is not enrolled that shall, at a minimum specify:

   1. The client must be enrolled in his home OTP for a minimum of thirty (30) days before being eligible for a guest dose and another OTP, unless approval is obtained by the SOTA prior to enrollment as a guest.
   2. The receiving program must have evidence of two (2) consecutive successful urine drug screens within a thirty (30) period prior to a client being enrolled for guest dosing, unless approval is obtained by the SOTA prior to enrollment as a guest.
   3. The sending program's responsibilities include, at a minimum:
      (a) Develop a document to utilize in transmitting all relevant client and dosing information to the receiving agency to request guest dosing privileges;
      (b) Forward this document to the receiving program;
      (c) Provide the client with a copy of the document that was sent to the receiving program;
      (d) Verify receipt of the information sent to the receiving program;

(e) Verify that the client understands all stipulations of the guest dosing process including, but not limited to, fees, receiving program contacts, dosing times and procedures;

(f) Accept the client upon return from guest dosing unless other arrangements have been made; and

(g) Document all procedures implemented in the guest dosing process in each client's case record.

4. The receiving program's responsibilities include, at a minimum:

   (a) Verify receipt of the sending program's request for guest dosing privileges and acceptance or rejection of the client for guest medication within forty-eight (48) hours of the request;

   (b) Communicate any requirements of the receiving program that have not been specified on the document submitted by the sending program;

   (c) Establish a process for medical personnel to verify dose prior to dosing; and

   (d) Document all procedures implemented in the guest dosing process in each client's case record.

5. If guest dosing exceeds fourteen (14) days, a drug screen shall be obtained.
6. Guest dosing shall not exceed twenty-eight (28) days.

J. No dose of methadone in excess of 120 milligrams may be ordered or administered without the prior approval of the SOTA.

K. Take-Home Privileges. The Program must develop, maintain, and document implementation of policies and procedures that govern the process utilized by the Medical Director and treatment team for determination of unsupervised consumption of medication, referred to as Take-Home Privileges. All information utilized to determine Take-Home Privileges must be documented in the individual's record, with documentation to include at a minimum, the following:

1. Absence of recent abuse of drugs and/or failed urine drug screens;
2. Regularity of clinic attendance;
3. No observed, reported, or otherwise known serious behavioral problems;
4. Absence of known recent criminal activity;
5. Stability of client's home environment and social relationships;
6. Length of time in treatment;
7. Assurance that take-home medication can be safely stored within the client's home;
8. Client possession of a secure locking storage device in order to receive the medication from the clinic (NO exceptions); and
9. Decisions and rationale for the approval of Take-Home Privileges.

L. The program will adhere to the following schedule of Treatment Phases based on the clinical judgment of the Medical Director and the treatment team's behavioral assessment of the individual served. The quantity of take-home medication and frequency of urine drug screens (UDS) must not be less restrictive than the following:

1. Phase 1 - During the first ninety (90) days of treatment, clients will successfully complete a minimum of two (2) UDSs pre month but will NOT be eligible for any take-home medication.
2. Phase 2 – During days 91-180 of treatment, clients will successfully complete one (1) UDS per month to be eligible for two (2) doses per week of take-home medication.
3. Phase 3 – During days 181-270 of treatment, clients will successfully complete one (1) UDS per month to be eligible for three (3) doses per week of take-home medication.
4. Phase 4 – During days 271-365 of treatment, clients will successfully complete one (1) UDS per month to be eligible for six (6) doses per week of take-home medication.
5. Phase 5 – During the second continuous year of treatment, clients will successfully complete one (1) UDS per month to be eligible for thirteen (13) doses of take-home medication.
6. Phase 6 – during the third and subsequent continuous years of treatment, clients will successfully complete one (1) UDS per month to be eligible for a one (1) month supply of take-home medication.

M. Temporary Take-Home Medication for non-emergency: The Program shall develop, maintain, and document implementation of written policies and procedures for the process to allow for temporary take-home medication for exceptional circumstances which shall include at a minimum:

1. The need for temporary take-home medication shall be clearly documented with verifiable information in the clinical record.
2. Client will meet the minimum requirements for Take-Home Privileges outlined in section 59.4G;
3. Assessed and authorized, as appropriate, for a Sunday, or legal holiday as identified by Section 3-3-7, Mississippi Code of 1972, Annotated (Amended in regular Session 1987, effective from and after passage March 20, 1987.);
4. Not allowed in short-term detoxification; and
5. Requests for temporary special take-home medication shall be approved in writing by the State Opioid Treatment Authority prior to dispensing and administering medication to the client.

N. Temporary Take-Home Medication for emergency: The Program shall develop, maintain, and document implementation of written policies and procedures for the

process to allow for temporary take-home medication for exceptional circumstances which shall include at a minimum:

1. The need for emergency take-home medication shall be clearly documented with verifiable information in the clinical record.
2. Requests for emergency take-home medication shall be approved in writing by the Program's Medical Director and shall not exceed a three (3) day medication supply at any one (1) time;
3. Requests for emergency special take-home medication shall be approved in writing by the SOTA prior to dispensing to the client.
4. Situations that might warrant emergency take-home medication include:
   (a) Death in the family;
   (b) Illness;
   (c) Inclement weather;
   (d) Other similar uniquely identified situations
5. Not allowed in short-term detoxification

O. Since the use of take-home privileges provides opportunity not only for diversion, but also accidental poisoning, the medical director~~/physician~~ and the treatment team must make every attempt to ensure that the Take-Home Medication is given only to individuals who will benefit from it and who have demonstrated responsibility in handling methadone. The program must have a written policy with documentation of implementation of a "call-back" procedure requiring a random schedule or with reasonable cause that the patient be required to return to the program with the amount of medication that should be remaining based upon prescribed dosing.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.6 Withdrawal Management

A. Medically supervised withdrawal management from a synthetic narcotic with a continuum of care must be a part of the treatment protocol for the Opioid Treatment Program. The program must develop, maintain, and document implementation of written policies and procedures that include, at a minimum:

1. A process for voluntary medically supervised withdrawal that shall:
   (a) Acknowledge that participation in the OTP is voluntary and that the client is free to leave treatment at any time;
   (b) Identify the steps to be taken by the program when a client and program staff agree on a need to initiate the withdrawal procedures;
   (c) Identify the steps to be taken by the program when a client requests withdrawal against the medical advice of the program staff; and

(d) Ensure availability of a variety of supportive options to improve the chances of a successful episode of medically supervised withdrawal.

2. A process for involuntary medically supervised withdrawal that shall:
   (a) Identify the circumstances under which involuntary administrative withdrawal procedures will be implemented;
   (b) Identify the steps to be taken to delineate the responsibilities of program staff in implementation of involuntary administrative withdrawal procedures;
   (c) Ensure availability of a variety of supportive options to improve the chances of a successful episode of medically supervised withdrawal; and
   (d) Provide for the referral or transfer of the client to an appropriate treatment program upon completion of the withdrawal process.
3. The program Medical Director shall approve all requests for voluntary and involuntary withdrawal from OTP.
4. The Medical Director shall establish an individual withdrawal dosage schedule in accordance with sound medical treatment and ethical considerations, and based on an objective assessment of each client's unique needs.
5. Each individual withdrawal schedule shall be for a time period of not less than thirty (30) days, unless otherwise clinically contraindicated with supporting documentation from the Medical Director.
6. Take-home medication shall NOT be allowed during medically supervised withdrawal.
7. A history of one (1) year of physiological dependence shall not be required for admission to an OTP for supervised withdrawal.
8. Clients who have two (2) or more unsuccessful detoxification episodes within a twelve (12) month period shall be assessed by the program Medical Director for other forms of treatment.
9. A program shall not admit a client for more than two (2) detoxification episodes in one (1) year.
10. Drug screens during detoxification shall be performed as follows:
    (a) An initial drug screen shall be performed at the beginning of the detoxification process.
    (b) At least one (1) random drug screen shall be performed monthly during the detoxification process.
11. Decreasing the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, within the tolerance level of the individual;
12. Counseling of the type and quantity designed to motivate the continuation of the withdrawal process;
13. Assurance that voluntary withdrawal would be discontinued and maintenance resumed in the event of impending relapse; and
14. Provisions for the continuance of care after the last dose of methadone.

B. Documentation must be maintained regarding the individual's condition during the total withdrawal process to include:

1. Signs and symptoms of medical and emotional distress;
2. Actions taken to avoid discharge; and

3. Progress of the individual served.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 55.7 Diversion Control

A. The Program must develop, maintain and document implementation of a written plan to reduce the possibilities for diversion of controlled substances from legitimate treatment to illicit use. The diversion control plan must include, at a minimum, policies and procedures for:

1. Continuous monitoring of clinical and administrative activities related to dosing and take-home dispensing practices to identify weaknesses and reduce the risk of medication diversion;
2. Problem identification and correction, including for prevention of related diversion problems;
3. Specific assignment of diversion control measures to staff members who are identified in the diversion control plan to demonstrate accountability to patients and the community;
4. Random and unannounced drug screening for all employees, including full-time or contract employees;
5. Video-camera surveillance in medication area(s), both within the dispensing area and outside the dispensing area with all monitoring conducted by the administrator and/or security personnel;
6. Surveillance in the parking lot of the clinic and surrounding areas, including security camera(s) with outdoor monitoring capabilities; and,
7. Loitering by individuals being served around the building and surrounding area(s) is not permitted.
8. Procedures for clients who are dispensed there (3) or more take-home doses to receive a minimum of two (2) call-backs annually;
9. Restriction of employees from taking purses or bags into the medication area(s); and
10. Only one client at a time at the medication window;

B. The Opioid Treatment Programs must have written procedures for handling bio hazardous medical waste material, which provide at a minimum the following:

1. Safe handling;
2. Safe storage; and
3. Safe disposal.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.8 Multiple Enrollments

A. The Program shall develop, maintain and document implementation of written policies and procedures established to ensure that it does not admit or provide medication for an individual who is enrolled in another OTP. The policies and procedures shall include the following at a minimum:

B. The SOTA shall establish written guidelines, incorporated herein by reference, for participation in a central registry process to aid in the prevention of multiple enrollment of a client in more than one OTP at the same time. Each OTP Program shall provide written documentation of adherence to the SOTA guidelines that shall, at a minimum, include the following:

1. The Program shall make a disclosure to the central registry at each of the following occurrences:
   (a) A client is admitted for opioid treatment;
   (b) A client is transferred to another provider for opioid treatment;
   (c) A client is discharged from opioid treatment;
2. Program shall make disclosures in the format and within the timeframes established by the SOTA.
3. Program shall limit disclosures to client identifying information and the dates of admission, transfer, and discharge.
4. Program shall obtain the client's written consent, in accordance with 42 CFR Part 2, prior to making any disclosures to the central registry.
5. Program shall inform each client of the required written consent for participation in the central registry before services are initiated.
6. Program shall deny admission to individuals who refuse to provide written consent for disclosures to the central registry and shall document these denials in the case record.

C. The Program shall obtain the client's written consent, in accordance with 42 CFR Part 2, to photograph the applicant at the time of admission. The photograph shall be maintained in the client's case record.

D. The Program shall require that all clients show proof of identification in the form of an official state driver's license or a non-driver's license issued by the state's Department of Public Safety. A copy of current identification will be maintained in the clinical record.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 55: Glossary

A. Basic bedroom furnishings – bed frame, mattress (at least 4 inches thick), box springs (if applicable to bed frame type), night stand, chest of drawers or dresser, lamp, nightstand, 2 sets of bed linens

B. Certified Peer Support Specialist (CPS) - CPS provide non-clinical peer support that is person-centered and recovery/resiliency focused. CPS is a self-identified consumer/family member (past or present) of mental health services who has successfully completed the Department of Mental Health approved Certified Peer Specialist training and certification exam.

C. Chemical restraint - a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.

D. Community-based - services and supports are located in or strongly linked to the community, in the least restrictive setting supportive of an individual's safety and treatment needs. Services and supports should be delivered responsibly and seamlessly where the person lives, works, learns and interacts.

E. Cultural Competency - the acceptance and respect for difference, continuing self-assessment regarding culture, attention to dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of minority populations.

F. Days - calendar days.

G. Director – an individual with overall responsibility for a service or service area. This individual must have at least a Master's degree in a mental health or related field and (1) a professional license or (2) DMH Credentials as a Mental Health Therapist or DMH credentialed Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served and/or supervised).

H. DMH Credentials – examples include Certified Mental Health Therapist (CMHT), Certified Intellectual or Developmental Disabilities Therapist (CIDDT).

I. Grievance - a written statement made by an individual receiving service alleging a violation of rights or policy.

J. Immediate family members - spouse, parent, stepparent, sibling, child, or stepchild.

K. Legal representative – the legal guardian or conservator for an individual as determined in a court of competent jurisdiction.

L. Mechanical restraint - the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

M. Medical Screening - Components of medical screening include: patient personal information, doctor's information (name, etc.), exam information – BP, pulse, height, weight, current diagnosis, current meds, statement of freedom from communicable disease, physical and dietary limitations and allergies. Must be signed by a licensed physician/nurse practitioner.

N. Peer - A self-identified consumer or family member of a consumer of mental health services.

O. Peer Support Service - Peer Support Services are person-centered activities that allow consumers/family members the opportunity to direct their own recovery and advocacy processes. Peer Support is a helping relationship between peers and/or family member that is directed toward the achievement of specific goals defined by the individual. Peer Support Services include a wide range of structured activities to assist individuals in their individualized recovery/resiliency process. Specific goals may include the areas of wellness and recovery/resiliency, education and employment, crisis support, housing, social networking, development of community roles and natural supports, self-determination and individual advocacy.

P. Peer Support Supervisor - An individual credentialed according to the standards and guidelines determined by DMH. Prior to, or immediately upon acceptance in a Peer Support Supervisory position, this individual will be required to receive basic Peer Specialist training specifically developed for supervision within the Peer Specialist program, as provided by DMH.

Q. Person Centered Planning – A best practice approach to planning for people who require life-long supports and services. Person Centered Planning discovers and acts on what is important to a person as well as what is important for a person. Person Centered Thinking© principles are used to gather information with and from participants of the person's choosing. The person and his/her team develop individually tailored outcomes that are molded into activities to assist people in having meaningful days and in doing what they choose to do.

R. Person-Centered, Recovery Oriented System of Care – identification of the supports needed for individual recovery and resilience. Individualized and person-centered means that the combination of services and supports should respond to an individual's needs, and should work with the strengths unique to each individual's natural and community supports. Services and supports should be designed to help the person served identify and achieve his/her own recovery goals. The public mental health system must also recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation. However, an individualized/person-

centered process must recognize the importance of the family and fact that supports and services impact the entire family.

S. Person Centered Thinking – Person Centered Thinking underlies and guides respectful listening which leads to actions, resulting in people who: Have positive control over their life; are recognized and valued for their contributions (current and potential) to their communities; and are supported in a web of relationships, both natural and paid, within their communities. © TLC-PCP

T. Physical escort - the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.

U. Physical restraint - personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.

V. Professional License – examples include Licensed Professional Counselor (LPC), Licensed Psychologist, Licensed Master Social Worker (LMSW), Licensed Certified Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Medical Doctor.

W. Program - the single service provision site.

X. Provider - the overall agency/entity. Provider does not refer to an individual staff member or program site.

Y. Psychiatric Services – includes interventions of a medical nature provided by medically trained staff to address medical conditions related to the individual's mental illness or emotional disturbance. Medical services include medication evaluation and monitoring, nurse assessment, and medication injection.

Z. Results-oriented - services and supports that lead to improved outcomes for the person served. People have as much responsibility and self-sufficiency as possible, taking into consideration their age, goals and personal circumstances. Recovery- oriented services means services that are dedicated to and organized around actively helping each individual served to achieve full personal recovery in their real life and service environment.

AA. Seclusion - a behavior control technique involving locked isolation. Such term does not include a time-out.

BB. Supervisor - an individual with predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services for such areas as Work Activity Services, Day Services-Adults, Psychosocial Rehabilitation Services, Day Support Services, etc. This individual must have at least a Bachelor's degree in a Mental Health, Intellectual/Developmental Disabilities, or a related field, and be under the

supervision of an individual with a Master's degree in a Mental Health, Intellectual/Developmental Disabilities, or a related field.

CC. Time Out - behavior management technique which removes an individual from social reinforcement into a non-locked room, for the purpose of calming. The time-out procedure must be part of an approved treatment program.

Operational Standards
For
Mental Health,
Intellectual/Developmental Disabilities,
and Substance ~~Abuse~~ Use Disorders
Community Service Providers

Effective July 1, 2016 ~~Effective November 1, 2013~~

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Title 24: Mental Health

Part 2: Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance ~~Abuse~~ Use Disorders Community Service Providers

Part 2: Chapter 1: Certification Responsibilities of the Mississippi Department of Mental Health

Rule 1.1 Repeal of Prior Rules

Upon their effective date, these rules and regulations supersede and repeal all previous versions of the Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance ~~Abuse~~ Use Disorders Community Service Providers.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 1.2 Legal Authority

D. The State of Mississippi vested standard-setting authority in the DMH through Section 41-4-7 of the *Mississippi Code, 1972, as amended*, which authorizes the Department to:

    4. supervise, coordinate, and establish standards for all operations and activities of the state, related to mental health and providing mental health services;

    5. certify, coordinate and establish minimum standards and establish minimum required services for regional mental health and intellectual disability commissions and other community service providers for community or regional programs and services in mental health, intellectual disability, alcoholism, drug misuse, developmental disabilities, compulsive gambling, addictive disorders and related programs throughout the state; and,

    6. establish and promulgate reasonable minimum standards for the construction and operation of state and all DMH certified facilities, including reasonable minimum standards for the admission, diagnosis, care, treatment, transfer of patients and their records, and also including reasonable minimum standards for providing day care, outpatient care, emergency care, inpatient care and follow-up care, when such care is provided for persons with mental or emotional illness, intellectual disability, alcoholism, drug misuse and developmental disabilities.

E. Mental Health Services described in these regulations are approved therapeutic and case management services provided by (a) an approved regional mental health/intellectual

disability center established under Sections 41-19-31 through 41-19-39, or by another community mental health service provider meeting the requirements of the Department of Mental Health (DMH) to be an approved mental health/intellectual/developmental center if determined necessary by DMH, using state funds which are provided from the appropriation to DMH and/or funds transferred to the department by a political subdivision or instrumentality of the state and used to match federal funds under a cooperative agreement between the division and the department, or (b) a facility certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior authorization of the Division of Medicaid to be eligible for reimbursement under this section.

F. As described in Senate Bill 2829 of Regular Session 2014, regional commissions can create and operate a primary care health clinic to treat (a) its patient; (b) its patients' family members related within the third degree; and (c) its patients' household members or caregivers. Regional commissions operating a primary care health clinic must satisfy applicable state and federal laws and regulations regarding the administration and operation of a primary health care clinic. DMH does not have the statutory authority to license, certify or monitor primary care health clinics.

Source: Section 43-13-117(16) of *the Mississippi Code, 1972, as amended*
Section 41-19-33 *of the Mississippi Code, 1972, as amended*

Part 2: Chapter 2: Certification

Rule 2.1 DMH Provider Certification Types

I. Certification by the Mississippi DMH of any type is not a guarantee of funding from any source. Funding is a separate process and each individual funding source/agency must be contacted for information regarding their requirements for funding and the process required for obtaining that funding.

J. Certification by the Mississippi DMH of any type is not a guarantee of designation as a DMH Mental Health/Intellectual Disability/ Substance Use Disorder ~~Abuse~~ Community Service Provider.

K. DMH/Department (DMH/D): Programs that are operated under the authority and supervision of the State Board of Mental Health authorized by Section 41-4-7 of the *Mississippi Code of 1972, Annotated*, must be certified. These are the community based services, including those community mental health service providers meeting DMH requirements of and determined necessary by DMH to be an approved Community Mental Health Center, operated by the state regional centers and the state psychiatric/chemical dependency hospitals.

L. DMH/CMHC (DMH/C): Providers that are certified under this option are Community Mental Health Centers operating under the authority of regional commissions established under 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*, and other community mental health service providers operated by entities other than the DMH that meet requirements of and are determined necessary by DMH to be a designated and approved mental health center.

M. DMH/Private Provider (DMH/P): Providers certified by DMH to provide therapeutic and case management services, to be reimbursed on a fee for service basis. Any such services provided by a facility described in paragraph (b) must have the prior authorization of the Division of Medicaid to be eligible for reimbursement under this section. DMH is not responsible for any required matching funds for reimbursement for this provider certification type.

N. DMH/Grants (DMH/G): Providers other than those designated as DMH/D and DMH/C above that receive funds for services through grants from the Mississippi DMH must be certified. These include nonprofit providers that receive funds directly from the DMH, but that are not Community Mental Health Centers (DMH-C designation) or DMH-operated (DMH/D designation).

O. DMH/Home and Community-Based Waiver (DMH/H): Providers meeting requirements for certification to provide services under the Home and Community-Based Services-ID/DD Waiver must be certified by DMH. All DMH/H Providers must be enrolled as a Medicaid provider for ID/DD Waiver Services prior to service delivery. Entities that

may apply include those already certified by the DMH as well as other entities that provide the type services offered through the ID/DD Waiver.

P. DMH/Other Agency Requirement or Option (DMH/O): Private nonprofit and private for-profit providers that receive funds from agencies other than the Mississippi DMH (such as from the Mississippi Department of Rehabilitation Services and the Mississippi Department of Human Services) may be required by that agency to obtain DMH certification. These providers will be designated as DMH/O programs if applicable DMH Standards are met.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*
Section 43-13-117 of the *Mississippi Code, 1972, as amended*

Rule 2.2 Fees

D. A fee may be charged by the DMH for certification or recertification depending on the certification option the provider chooses and the legal status of the applicant organization (i.e., private non-profit, private for-profit, public, etc.). After submitting an initial application, the applicant will be contacted in writing by the DMH notifying the provider of the fee (if applicable). The fee must be submitted to the DMH prior to the initial on-site visit.

E. A fee to conduct the initial certification visit of $350.00 per DMH staff person per day may be charged to programs seeking DMH/O, DMH/P and providers seeking DMH/H certification. Those programs seeking or holding a DMH/D, DMH/C, a DMH/G certificate, will be exempt from fees.

F. Recertification or other review visits may require a fee of $150.00 per DMH staff person per day, which will be billed to the provider after the on-site visit.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.3 DMH Provider Certification for New Service Providers

F. A new service provider is defined as an organization that is seeking DMH certification as a service provider with organizational and management structures in place to meet requirements outlined in DMH Operational Standards to begin service provision.

G. New Service Providers interested in DMH Certification must complete DMH Provider Orientation prior to seeking certification. DMH Provider Orientation must be completed prior to submitting the application for DMH Provider Certification.

H. New Service Providers interested in DMH Certification must submit the required DMH application and supporting documentation and adhere to the timelines and procedures for application.

I. DMH certification for all new service provider organizations is a two-step process.

3. First, a service provider organization must receive DMH Provider Certification.
4. Second, the DMH certified provider must apply for DMH certification of the services they seek to provide and the applicable program locations in which the services are provided. *(Note: not all services will require a physical program location)*

J. DMH will notify the Division of Medicaid of a provider's certification status.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 2.4 DMH Provider Certification of New or Additional Services</u>

E. All DMH Certified Providers seeking DMH certification of new or additional services must submit the completed DMH Service Certification Application and supporting documentation to the Division of Certification for review. Applicants must adhere to the timelines and procedures for application. Incomplete applications will not be considered for review.

F. All services and program locations must be certified by DMH, with written documentation of effective certification period prior to service delivery and seeking reimbursement for services. DMH will notify the Division of Medicaid of a provider's certification status.

G. ~~F.~~ <u>In addition to the requirement of Rule 2.4.A-B p</u>roviders seeking DMH certification to provide Host Home Services must provide documented evidence of at least two (2) years of experience of managing and provide Host Home Services to include organizing, certifying and managing Host Home families.

H. ~~C.~~ In addition to the requirement of Rule 2.4 A, entities applying for ~~approval to open and operate~~ certification as a Opioid Treatment Program ~~Utilizing Methadone~~ must include the following:

2. Program goals and objectives;
~~3. Program methodology;~~
4. ~~3.~~ Program funding (including individual fee schedules);
5. ~~4.~~ Demonstrated need to establish ~~a~~ <u>the</u> program. ~~A valid needs assessment and sufficient justification of the appropriateness of the service in the geographical area in which it intends to operate must be approved by DMH.~~
~~5. Documentation of support be in the form of signed letters submitted directly from the supporter/agency to the DMH within six (6) months of the date of the application being filed with the DMH. This documentation of support at a minimum must include the following:~~
   (a) <u>Submit sufficient justification to include:</u>
      (1) <u>Location population data</u>

(2) Agencies plan for service implementation
(3) Identified Gaps in service
(4) Expected target population
(5) Sufficient documentation of support for services in the form of a signed letter from at least one of the following:
iv. Individuals
v. Businesses
vi. Property-owners residing/located within the immediate area surrounding the proposed location
(6) Sufficient documentation of need in the form of a signed letter from at least one of the following:
iv. Behavioral health program
v. Area physician
vi. Other health professional/agency
(7) Sufficient documentation of support for services in the form of a signed letter from at least one of the following:
iv. Local governing authorities
v. Local law enforcement officials
vi. Local judges

~~a. Documentation of request for the program from individuals, business, and property-owners residing/located within a fifty (50) mile radius surrounding the proposed location.~~

~~b. Documentation of need for the program from at least two (2) existing behavioral health programs, area physicians and other health professionals/agencies in the area of proposed location. Existing service providers and programs in the area means Mississippi-based programs geographically located within a fifty (50) mile radius service area of the program.~~

~~c. Written documentation of need for the program from local governing authorities, law enforcement officials, and judges. Local governing authority is defined as Mayor in an incorporated area indicating the written approval of the Board of Aldermen or the City Council. In an unincorporated area, the President of the Board of Supervisors must indicate approval. Law enforcement officials are defined as the Chief of Police in an incorporated area and the Sheriff of the county in which the program is to be located. A Judge for the purpose of these standards is defined as one or more judges in the fifty (50) mile radius service area that has jurisdiction over drug-related cases.~~

F. ~~D.~~ An Opioid Treatment Program ~~Utilizing Methadone~~ will not be approved if its planned location is ~~planned within sixty (60) miles of any existing Opioid Treatment Program.~~ in an area where needs are met by existing services. The DMH determination of need will include but is not limited to population census, existing services, and other pertinent data. This applies to initial and future satellite or branch sites of ~~existing~~ Opioid Treatment Program(s).

G. ~~E.~~ An Opioid Treatment Program utilizing methadone must be located in an area that is properly zoned in accordance with local ordinances and requirements.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.5 DMH Certification Criteria

D. DMH issues Provider, Service, and Program Certifications for a three (3) year certification cycle unless stated otherwise at the time of certification.

E. DMH Certification is based on the following:

7. Provision of applicable required services in all required locations for desired certification option;
8. Adherence to DMH standards, DMH grant requirements (if applicable) guidelines, contracts, memoranda of understanding, and memoranda of agreement;
9. Compliance with DMH fiscal management standards and practices;
10. Evidence of fiscal compliance/good standing with external (other than DMH) funding sources;
11. Compliance with ethical practices/codes of conduct of professional licensing entities related to provision of services and management of the organization; and
12. Evidence of solid business and management practices.

F. In addition to complying with the appropriate areas of the current DMH Operational Standards for MH/IDD/~~SA~~ SUD Community Providers, a program or provider must comply with special guidelines and/or regulations issued by the ~~Mississippi~~ DMH for the operation of programs and services and must update the Policies and Procedures Manual(s) and other documentation as required by these guidelines and/or regulations.

D. In addition to applicable standards, programs certified and/or funded by the Mississippi DMH must comply with any additional specifications set forth in individual program grants/contract as well as with the requirements outlined in the DMH Record Guide.

E. Providers must maintain current and accurate data for submission of all reports and data, within established time frames, as required by the DMH according to the DMH Manual of Uniform Data Standards.

F. Providers must comply with requirements of DMH Provider Bulletins.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.6 Certification Reviews

E. Administrative and On-Site Compliance Reviews will take place (if applicable) for the certification of the following:

6. New service provider organizations
7. New services or program locations for an existing DMH Certified Provider
8. Additional services or program locations for an existing DMH Certified Provider
9. Adherence to an accepted Plan of Compliance
10. During the certification period of a certified provider to ensure continued adherence to DMH Operational Standards, guidelines, contracts, and grant requirements. DMH reviews may be unannounced.

F. Administrative Compliance Reviews are defined as reviews during which DMH requests information (such as policies and procedures, staffing plans, staff training, minutes of governing authority, etc.) be submitted from the provider for a DMH administrative review.

G. On-site Compliance Reviews are defined as reviews that are conducted by DMH at the administrative, service or program location.

H. All DMH funded/certified providers, services and programs are subject to a DMH-approved peer review/quality assurance evaluation process.

4. The Peer Review Program is committed to the involvement of consumers, family members, mental health professionals and interested stakeholders in program evaluation and moving the system toward a person driven, recovery/resiliency oriented system.
5. The goal of the Peer Review Program is to advocate for excellence in services through the voices of the people being served, to improve care in the public mental health system, and to ensure services meet the expressed needs of individuals receiving services.
6. Consumers, Family members, mental health professionals and interested stakeholders comprise the peer review team. Team members obtain information from peers and program staff about satisfaction with services, quality of life measures, support provided from professional staff; review programs and case records (when applicable); and dialogue with mental health administrators. The team provides feedback to providers and DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.7 DMH Written Reports of Findings

If found to be out of compliance with the criteria for DMH Certification during an administrative or on-site compliance review, DMH will issue a Written Report of Findings to the Executive Director and Chairperson of the Governing Authority of the provider organization within thirty (30) days of the last day of the compliance review. The provider is informed that termination of certification will be effective within one hundred and twenty (120) calendar days from the last day of the review. The termination date will be included in the Written Report of Findings.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.8 Plan of Compliance

E. Upon receipt of a DMH Written Report of Findings, a DMH Certified Provider must submit a Plan of Compliance (POC) in the required format included in the DMH Record Guide to the Division of Certification within thirty (30) days of the date of the Written Report of Findings. The POC must address the corrective action by the Provider, date of corrective action, timelines for completion of corrective action, and measures put in place to maintain compliance and prevent future occurrence. Should the provider not submit a POC within the required timeframe, the process to terminate certification will continue as stated in Rule 2.7. DMH will not make additional requests for a POC to be submitted.

F. Timelines for the submission of a POC may be revised due to the nature of findings. If applicable, DMH will notify the Certified Provider of a revision in timelines in the Written Report of Findings.

G. If the POC is accepted by DMH, the Provider will be notified in writing within thirty (30) days of the date of DMH receipt of the POC.

H. If the POC is not found to be acceptable by DMH, the Provider will be notified in writing within thirty (30) days of the date of DMH receipt of the POC. If the POC is not accepted by DMH, the Provider is notified in writing that the termination of certification will be effective as stated in the DMH Written Report of Findings.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 2.9 Administrative Suspensions or Termination of Certification

F. Based on issues of noncompliance, DMH may determine the need to take administrative action to suspend, revoke or terminate certification. This decision is made by the DMH Executive Director or his designee.

G. A determination that the certification status may be suspended or terminated shall be made upon any of the following criteria:

9. Failure to comply with DMH Operational Standards;
10. Failure to comply with guidelines, contracts, memoranda of understanding, and memoranda of agreement;
11. Failure to comply with DMH fiscal requirements;
12. Failure to provide services for a period of twelve months;
13. Defrauding an individual receiving services, individual that may potentially receive services, and/or third party payer sources;
14. Endangerment of the safety, health, and/or the physical or mental well-being of an individual served by the provider agency;
15. Inappropriate or unethical conduct by provider staff or its governing authority; or

16. Any other just cause as identified by the MS State Board of Mental Health/DMH Executive Director.

H. DMH will notify the Executive Director and the Chairperson of the governing authority of the provider agency in writing of an administrative suspension or termination and the criteria for which that determination was made.

I. Should DMH Administratively suspend a certified provider, service or program, the Executive Director of the provider agency will have the opportunity to submit a POC to DMH for approval in order to have the administrative suspension lifted. The timelines for submission of the POC in Rule 2.8 will apply unless otherwise stated by DMH.

J. Should DMH terminate the certification of a provider, the provider cannot reapply for DMH certification for a period of one year from the date of the termination.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 3: Service Options

Rule 3.1 Core Services for DMH/C and DMH/P Providers

C. Community Mental Health Centers operated under the authority of regional commissions established under MCA Section 41-19-31 et seq. and other community mental health service providers operated by entities other than the DMH that meet DMH requirements of and are determined necessary by DMH to be a designated and approved mental health center must provide the following core services in each county in the CMHC's entire catchment area and in each county identified by DMH/P providers:

5. Adult Mental Health Services

   a. Outpatient Therapy
   b. Community Support Services
   c. Psychiatric/Physician Services
   d. ~~Emergency/~~Crisis Response Services
   e. Psychosocial Rehabilitation
   f. Inpatient Referral
   g. Pre-Evaluation Screening for Civil Commitment (required only for centers operated by regional commissions est. under MCA Section 41-19-31 et seq.)
   h. Peer Support Services
   i. Targeted Case Management Services
   j. Support for Recovery/Resiliency Oriented Services

6. Children and Youth Mental Health Services

   a. Day Treatment Services
   b. Outpatient Therapy
   c. Community Support Services
   d. Psychiatric/Physician Services
   e. ~~Emergency/~~Crisis Response Services
   f. Pre-Evaluation Screening for Civil Commitment (for youth age 14 and over)
   g. Making a Plan (MAP) Teams
   h. Targeted Case Management Services
   i. Peer Support Services
   j. Support for Recovery/Resiliency Oriented Services

7. ~~Alcohol and Other Drug~~ Substance Use Disorders Services

   f. Outpatient Services
   g. Crisis Response Services
   h. ~~b.~~ Prevention Services
   i. Peer Support Services
   j. Support for Recovery/ Resiliency Oriented Services

8. Intellectual/Developmental Disabilities Services

   a. ~~Emergency/~~Crisis Response Services

B. Community Mental Health Centers operated under the authority of regional commissions established under MCA Section 41-19-31 et seq. and other community mental health service providers operated by entities other than the DMH that meet DMH requirements of and are determined necessary by DMH to be a designated and approved mental health center (DMH/C) must provide the following core services for individuals in need of ~~alcohol and/other drug~~ substance use disorders treatment and rehabilitation services residing in the CMHC's entire catchment area:

4. Primary Residential ~~Treatment~~ Services (adults)
5. DUI Assessment Services
6. Recovery Support Services

Source: Section 41-4-1 of the *Mississippi Code, 1972, as amended*

Rule 3.2 Intellectual/Developmental Disabilities Waiver Services

B. Services available through the ID/DD Waiver include:

1. Support Coordination
2. Home and Community Supports
3. In-Home Nursing Respite
4. In-Home Respite
5. ~~4.~~ Day Services – Adult
6. ~~5.~~ Prevocational Services
7. ~~6.~~ Supported Employment
8. ~~7.~~ Supported Living
9. Shared Supported Living
10. ~~8.~~ Supervised Living
11. ~~9.~~ Host Homes
12. ~~10.~~ Community Respite
13. ~~11.~~ Crisis Intervention
14. ~~12.~~ Crisis Support
15. ~~13.~~ Behavior Support ~~and Intervention~~
16. ~~14.~~ Job Discovery
17. ~~15.~~ Transition Assistance

~~C. Providers of Supervised Living Services made available through the ID/DD Waiver must also provide Supported Living Services as an opportunity for individuals being served in Supervised Living Services to move into a more integrated and independent level of service/support.~~

Rule 3.3 IDD Community Support Program Services

A. Services available through the IDD Community Support Program include:

1. Day Habilitation
2. Prevocational Services
3. Supported Employment

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 4: Certificates of Operation

Rule 4.1 Certificates of Operation

B. All certified providers, services and programs must have a DMH Certificate of Operation.

B. The following apply to a Certificate of Operation:
   8. The valid dates of certification, service(s), or programs certified, including the physical location, site capacity of the program, if appropriate, and the certificate number will be specified on the Certificate of Operation issued by the DMH;
   9. A Certificate of Operation is not transferable;
   10. A Certificate of Operation is valid only for the service(s) or programs, physical location, and capacity identified on the certificate (in those cases where a definitive number or a quantitative capacity can be assigned to a service or program);
   11. Site capacities must not exceed the number identified on the Certificate of Operation;
   12. Certification for any established period, service or program is contingent upon the program's continual compliance with current Operational Standards for Mental Health, Intellectual/Developmental Disabilities and/or Substance ~~Abuse~~ Use Disorders Community Service Providers as established by the DMH;
   13. The Certificate of Operation must be posted in each of the certified sites for public view;
   14. Certificates for closed services and/or programs must be removed from the site and returned to the DMH within fifteen (15) days of the last day individuals were served.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 5: Waivers

Rule 5.1 Waivers of DMH Standards

I. A waiver of a specific standard may be requested and granted for a specified amount of time, determined on a case-by-case basis by the DMH, in accordance with the following procedures in this rule:

J. To request a waiver of a specific standard, the provider's Executive Director must make a written request to the Division of Certification. The request must:

1. List the standard(s) for which a waiver is being requested
2. Describe, in detail, all operational systems, personnel, etc., which function to meet the intent or objective of the standard
3. Provide justification that the waiver of the standard, if approved, will not diminish the quality of service
4. Designate individual program location(s) for which the waiver is requested
5. Specify the length of time for which the waiver is requested.

K. The DMH Review Committee and other personnel, as appropriate, will review the waiver request, and the Committee will approve or deny the request.

L. The Executive Director of the provider agency making the request will be notified of the decision within thirty (30) days of receipt of the request. Should DMH request additional information to make a determination regarding the waiver request, DMH has thirty (30) days from the date the requested information is received to make a determination and notify the Executive Director of the provider agency of the decision.

M. Should the requested information not be provided to DMH, Division of Certification within (30) days of the date DMH requests additional information needed to make a determination regarding a waiver request, the waiver request will be considered void. The provider agency requesting the waiver will be required to resubmit the request. Void waiver requests will not be kept on file.

N. Appeal of the denial of requests for waivers must be in accordance with Chapter 6 - Appeal Procedures.

O. Waivers granted by DMH serve only to waive a DMH Standard.

P. DMH waivers are time-limited for the time designated at the time the waiver is granted.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 6: Appeals

Rule 6.1 Appeals Related to Certification

B. Any provider applying for and/or holding certification by the DMH may appeal the following decisions and/or penalties:

5. Disapproval of a Plan of Compliance;
6. Any financial penalties invoked by DMH associated with noncompliance with the Operational Standards and/or audit findings;
7. Denial of a request for a waiver of a DMH Operational Standard; or
8. Termination of Certification.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 6.2 Procedures for Appeal

L. All appeals must be initiated by filing a written notice of appeal from the Executive Director or Governing Authority by certified mail in an envelope clearly marked Notice of Appeal or by email with Notice of Appeal in the subject line with the DMH ~~Executive~~ Deputy Director and a copy to the Mississippi Department of Mental Health attorney within ten (10) days from the date of the final notification by the Department of Mental Health of the decision(s) being appealed (described above). The effective action of the decision(s) being appealed shall not be stayed during the appeal process except at the discretion of the Deputy Director.

M. The written notice of appeal must have as its first line of text Notice of Appeal in bold face type (specifically stating that the notice is in fact an appeal).

N. The written notice of appeal must contain:
3. A detailed statement of the facts upon which the appeal is based, including the reasons justifying why the program disagrees with the decision(s) and/or penalty(ies) imposed by the Department of Mental Health under appeal; and
4. A statement of the relief requested.

O. ~~The Executive Director will forward the appeal to the appropriate Bureau Director.~~ The ~~Bureau~~ Deputy Director will conduct the first level of review.

P. If the ~~Bureau~~ Deputy Director determines that the appeal merits the relief requested without any additional information requested by ~~Bureau~~ Deputy Director and/or DMH attorney, the appellant will be notified that the relief requested is granted within ten (10) days of receipt of the written appeal.

Q. If the ~~Bureau~~ Deputy Director determines that additional information is needed to make a decision or recommendation, additional written documentation from the appellant may be

requested within 10 days of receipt of the appeal. The ~~Bureau~~ Deputy Director will specify a time line by which the additional information must be received.

R. Within ten (10) days of the time set by the ~~Bureau~~ Deputy Director for his/her receipt of the additional information requested (described in F. above), the ~~Bureau~~ Deputy Director will:

1. Determine that the appeal merits the relief requested and notify the appellant that the relief requested is granted; or
2. Determine that the appeal does not merit the relief requested and issue a recommendation of such, justifying denial of the appeal to the Executive Director of the Department of Mental Health, who will conduct the second level of review of the appeal.

S. Within ten (10) days of receipt of a recommendation for denial of an appeal from the ~~Bureau~~ Deputy Director (as described in G.2. above), the Executive Director of the Department of Mental Health will make a final decision regarding the appeal and notify the appellant of the decision.

T. Time lines for review of appeals by the ~~Bureau~~ Deputy Director~~(s)~~ and Executive Director may be extended for good cause as determined by the Department of Mental Health.

U. If the Executive Director concurs with the findings of the ~~Bureau~~ Deputy Director(s) to deny the appeal, the appellant may file a written request by certified mail in an envelope clearly marked Notice of Appeal and addressed to the Executive Director's office or by email with the Notice of Appeal in the subject line, requesting a review of the appeal by the Mississippi State Board of Mental Health. The request must be received by the Department within ten (10) days after the date of the notice of the Executive Director's decision to deny the appeal.

V. The written notice of appeal described in J. above must have as its first line of text Notice of Appeal in bold face type (specifically stating that the notice is in fact an appeal).

L. The written request for review of the appeal by the Mississippi State Board of Mental Health must contain:

1. A detailed statement of the facts upon which the request for review of appeal is based, including the reasons justifying why the program provider disagrees with the decision(s) by the Executive Director of the Department of Mental Health; and
2. A statement of the relief requested.

M. The Mississippi State Board of Mental Health review of appeals under this section will be in compliance with the established policy of the Board regarding appeals.

N. The Mississippi State Board of Mental Health review of appeals under this section may be based upon written documentation and/or oral presentation by the appellant, at the discretion of the Board.

O. Decisions of the Mississippi State Board of Mental Health are final.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 7: General Related to Certification

Rule 7.1 Access

A. Representatives of the DMH, displaying proper identification, have the right to enter upon or into the premises of any provider, program or facility it certifies at all reasonable times. The provider must comply with all reasonable requests to obtain information and to review individual cases, personnel and financial records and any other pertinent information. Failure to comply with legitimate requests may result in certification being withdrawn.

B. DMH program and fiscal staff have authority to interview personnel individually and individuals receiving services (if appropriate as determined by DMH) concerning matters regarding programmatic and fiscal compliance, including follow-up on matters reported to the DMH's Office of Consumer Support. Failure to comply with requests for such interviews will result in termination of the audit/review and possible discontinuance of funding and DMH certification.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 7.2 Technical Assistance

The DMH may provide, upon written request from the provider, technical assistance to applicants in maintaining requirements for certification. Additionally, the DMH may provide and/or facilitate other technical assistance ~~may be provided and/or facilitated by the DMH~~ when deemed necessary by the DMH. Technical assistance is not limited to, but may consist of contacts between DMH staff and the program staff via written correspondence, phone consultation, and/or personal visit(s).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 7.3 Changes to be Reported to DMH

D. Following certification, changes affecting the governing and/or operation of programs must be reported in writing to the Division of Certification. Anticipated changes must be reported before they take place. Changes not anticipated must be reported as soon as they occur. Failure to report any changes described in this section may result in loss of certification.

E. Examples of the significant changes that must be reported to the DMH before they occur include, but are not limited to:

4. Changes in the governing authority, executive and key leadership
2. Changes in ownership or sponsorship
3. Changes in staffing that would affect certification status
4. Changes in program site location

5. Increase in the capacity above that specified on the DMH certificate
6. Changes in program scope (such as major components of a service, age ranges and/or the population served, etc.)
7. Major alterations to buildings which house the program(s)
8. Changes in operating hours
9. Change(s) in the name(s) and/or locations of program(s) certified by the DMH.

F. Examples of significant changes that must be reported as soon as they occur include, but are not limited to:

1. Termination of operation (closure) for a period of one (1) day or more due to inclement weather or other unforeseen circumstances.
5. Termination or resignation of the governing authority member(s), Executive Officer, and key leadership.
6. Litigation that may affect service provision.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 8: Organization and Management

Rule 8.1 Governing Authority

C. The provider must have documented evidence of the source of its governing authority, whether corporate non-profit, corporate for-profit, sole proprietorship, charitable or governmental board/commission, or other such authority.

D. If the governing authority is a corporate non-profit or a charitable or governmental board/commission the governing authority must have and comply with bylaws and/or policies that:

9. Establish in writing the means by which the governing authority provides for the election or appointment of its officers and members and the appointment of committees necessary to carry out its responsibilities;
10. Show documentation of the adoption of a schedule of meetings and quorum requirements;
11. Require at least quarterly meetings;
12. Provide assurance that the governing authority does not consist of employees or immediate family members of employees;
13. Provide assurances that meetings of the governing authority are open to the public and include procedures for notifying the public of meetings;
14. Assure that governing authority members do not receive a per diem that exceeds the state limit;
15. Require the minutes of meeting, which are to include, but not be limited to:
    (a) The date of the meeting
    (b) Names of members and other participants/visitors attending
    (c) Topics and issues discussed, motions, seconds, and votes
    (d) Public comments; and
16. Establish an organizational structure as evidenced by an organizational chart.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 8.2 Annual Review by Governing Authority

B. The governing authority of all providers must have written documentation of the following:

1. Annual budget
2. Written affiliation agreements
3. All changes in policies and procedures
4. Annual Operational Plan submitted to DMH
5. Disaster and Continuity of Operations Plan

6. Process for meaningful individual and family involvement in service system planning, decision making, implementation and evaluation. Individuals should be provided the opportunity for meaningful participation in planning at least for their service area.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 8.3 Regional MH/IDD Commissions

C. Regional Commissions established must describe in their bylaws and/or policies their duties as designated under Section 41-19-33 (a) through (w) of the *Mississippi Code 1972, Annotated.*

D. Regional Commissions must also maintain written documentation of the following:

12. Public education activities (presentations, distribution of printed materials, other media) designed to promote increased understanding of the problems of mental illness, behavioral/emotional disorders of children, intellectual/developmental disabilities, alcoholism, developmental and learning disabilities, narcotic addiction, drug abuse and drug dependence and other related problems including the problems of the aging and those used to promote increased understanding of the purposes and methods of rehabilitation of such illnesses or problems.
2. Documentation of hazard, casualty or worker's compensation insurance, as well as professional liability insurance.
3. Written approval of the DMH and/or the County Board of Supervisors, depending on the original source of funding, prior to the disposal of any real and personal property paid for with state and/or county appropriated funds.
4. Authority of the commission to provide and finance services through various mechanisms and to borrow money from private sources for such, if needed.
5. If the Regional Commission has entered into a managed care contract(s) or any such arrangement affecting more than one region, written prior approval by the DMH of such contract/arrangement before its initiation and annually thereafter.
6. If the Regional Commission provides facilities and services on a discounted or capitated basis, when such action affects more than one region, written prior approval by the DMH of such provision before its initiation and annually thereafter.
7. If the Regional Commission enters into contracts, agreements or other arrangements with any person, payer, provider or other entity, pursuant to which the regional commission assumes financial risk for the provision or delivery of any services, when such action affects more than one region, written prior approval by the DMH of such provision before its initiation and annually thereafter.
8. If the Regional Commission provides direct or indirect funding, grants, financial support and assistance for any health maintenance organization, preferred provider organization or other managed care entity or contractor (which must be operated on a nonprofit basis), when such action affects more than one region, written prior approval by the DMH, of such action before initiation and annually thereafter.

17. If the Regional Commission forms, establishes, operates and/or is a member of or participant in any managed care entity (as defined in Section 83-41-403(c) of the *Mississippi Code of 1972, Annotated, as amended*), when such action affects more than one region, written prior approval by the DMH, of such action before initiation and annually thereafter.
10. At a minimum, an annual meeting by representatives of the Regional Commission and/or Community Mental Health Center with the Board of Supervisors of each county in its region for the purpose of presenting the region's total annual budget and total services system;
11. Efforts to provide or provision of alternative living arrangements for persons with serious mental illness, including, but not limited to, supervised living services.

Source: Section 41-19-33 of the *Mississippi Code, 1972, as amended*

Rule 8.4 Policies and Procedures Manual

D. The provider must have and comply with written Policies and Procedures Manual(s) which addresses all applicable administrative rules and standards in Title 24 Mental Health, Part 2 of the MS Administrative Code for all services provided. These written policies and procedures must give details of provider/agency implementation and documentation of the DMH Operational Standards for MH/IDD/SUAD Community Service Providers so that a new employee or someone unfamiliar with the operation of the program would be able to carry out the duties and functions of their position and perform all operations required by the organization, its services and programs.

E. The policies and procedures manual must:

4. Be reviewed at least annually by the governing authority, as documented in the governing authority meeting minutes
5. Be readily accessible to all staff, with a copy at each service delivery location
6. Describe how the manual is made available to the public.

F. The policies and procedures manual must be updated as needed, with changes approved by the governing authority before they are instituted, as documented in the governing authority meeting minutes. Changed sections, pages, etc., must show the date approved/revised on each page. Staff being affected by changes to the policies and procedures must review applicable changes. This review must be documented.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 8.5 Annual Operational Plans

K. Annual Operational Plans must be submitted by the Chairperson of the Regional Commission or Chairperson of the Governing Authority and the Executive Director of the agency to DMH by July 1 of each year by all DMH/C Providers, DMH/D Providers, and DMH/P Providers.

L. Annual Operational Plans for DMH/C, DMH/D, and DMH/P Providers that provide all or components of the core services (as identified in Rule 3.1 for DMH/C and DMH/P) must address the following:

8. The core services provided by the agency;
9. The geographical area in which core services are provided. Identified by each service and county;
10. Projected funding by major funding source (federal, state and local) for each core service;
11. The core services that the agency does not intend to provide;
12. Any other services outside of the core services being provided by the agency;
13. The geographical area in which services outside of the core services are provided. Identified by each service and county; and
14. Projected funding by major funding source (federal, state and local) for each service being provided outside of the core services.

M. DMH will approve or disapprove the Annual Operational Plan based on required standards and core services established by the Department. DMH will notify the provider in writing of approval/disapproval of the Annual Operational Plan.

N. If DMH finds deficiencies in the plan based on standards and core services required for certification, DMH shall give the provider a six (6) month probationary period to bring practices and services up to the established standards and required core services.

O. If after the six (6) month probationary period, DMH determines the provider still does not meet the standards and required core services for certification, DMH may remove the certification of the provider. The provider will then be ineligible for state funds from Medicaid reimbursement or other funding sources for those services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 9: Quality Assurance

B. Providers must put in place quality management strategies that at a minimum:

4. Allow for the collection of performance measures as required by DMH;
5. Develop a Quality Management Committee with responsibility for the oversight of collection and reporting of DMH required performance measures, written analysis of serious incidents, periodic analysis of DMH required client level data collection, review of agency wide Recovery and Resiliency Activities and oversight for the development and implementation of DMH required plans of compliance.
6. Collect demographic data to monitor and evaluate cultural competency and the need for Limited English Proficiency services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 10: Fiscal Management

Rule 10.1 Compliance

All DMH Certified Providers, regardless of type, must follow the rules and procedures outlined in this Chapter. Compliance with the rules in this section will be reviewed by the DMH Fiscal Auditors.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.2 Annual Budget

B. The provider must prepare and maintain annually a formal, written, program-oriented budget of expected revenues and expenditures for the program that must:

4. Categorize revenues for the program by source;
5. Categorize expenses by the types of services or program components provided, and/or by grant funding; and
6. Account for federal funds separately in accordance with the Single Audit Act of 1984.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.3 Fiscal Management System

B. The fiscal management system must:

3. Produce monthly financial reports that show the relationship of budget and expenditures, including both revenues and expenses by category, providing assurance that budgeted amounts in grants with DMH (if applicable) are not exceeded;
4. Provide monthly financial reports to the certified provider's governing authority and Executive Director as documented in Board minutes;
3. Provide for the control of accounts receivable and accounts payable; and for the handling of cash, credit arrangements, discounts, write-offs, billings, and, where applicable, individual accounts; and
4. Provide evidence that all generated income accounts are included in required fiscal audits.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.4 Financial Statements

B. Audited financial statements must be prepared annually by an independent Certified Public Accountant or, for state agency operated programs, the State Auditor's Office.

B. These financial statements:

5. Must include all foundations, component units, and/or related organizations.
6. Be presented to the agency's governing authority and to the DMH upon completion, but no later than nine (9) months of the close of the entity's fiscal year. Written Requests for extensions must be submitted to the DMH Director, Bureau of Administration to prevent interruptions in grant funding (if applicable).
7. Be in accordance with the Single Audit Act of 1984 (Office of Management and Budget (OMB) Circular A-133) for facilities which have expended $500,000 (or current threshold amount set by the Federal Office of Management and Budget) or more in Federal Financial Assistance (Detailed in Appendix 1 of the DMH Service Provider's Manual which can be found at www.dmh.ms.gov.).
8. Include a management letter describing the financial operation of the certified provider.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.5 Accounting Systems

C. Providers must develop a cost accounting system that defines and determines the cost of single units of service.

D. The provider must develop an accounting system to document grant match, and funds of individuals receiving services that:

1. Consists of a general ledger, cash disbursements journal, payroll journal, cash receipts journal, or other journals serving the same purpose, which are posted at least monthly.
2. Includes proper internal controls to prevent fraud, waste and abuse, including proper segregation of accounting duties (receipt, purchasing, recording, and reporting functions) and the requirement that all checks have two authorizing signatures.
3. Ensures that adequate documentation is maintained to support all transactions, including justification to support all types of cost allocation methods utilized, invoices, cancelled checks, etc. as well as time and attendance records to support personnel costs and approved travel vouchers and receipts to support travel.
4. Ensures that written contracts signed by both authorized service provider personnel and the contractor are secured for all contractual services charged to DMH grants (other than utilities) that specifies the dates that the contract is valid as well as the services and/or duties for which the service provider is purchasing.
5. Ensures that Federal funds are expended in accordance with the applicable federal cost principles (OMB Circular A-122 for independent, non-profits and OMB Circular A-87 for State and local governments) and that all funds are expended in accordance with guidelines outlined in the DMH Service Provider's Manual.
6. Ensures that all accounting and financial personnel adhere to the ethical standards of their profession and that provides for appropriate training of accounting and financial staff to prevent misuse of program and funds of individuals receiving services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.6 Purchasing

B. The certified provider must develop and adhere to purchasing policies and procedures that ensure:

1. Proper internal controls over the procurement, storage, and distribution functions are in place and in accordance with federal and state regulations, including proper oversight and segregation of duties between the purchasing, receiving, and recording functions.
2. Regional Mental Health Centers and state agency operated programs adhere to the laws and regulations published by the State of Mississippi Department of Finance and Administration (DFA) Procurement Manual. These regulations can be found on DFA's website (www.dfa.state.ms.us).
3. The provider maintains adequate documentation to support all purchasing transactions (e.g. requisitions, bids, purchase orders, receiving reports, invoices, canceled checks and contracts).
4. The provider maintains an inventory system accounting for all grant purchased equipment that includes a master listing of all equipment with, at a minimum, the serial number of the equipment item, the cost of the equipment item, the date that the item was purchased, the grant funded program for which the item was purchased, and the unique inventory number assigned to the item by the facility. A label with this unique inventory number must be affixed to the equipment item.
5. The provider reports to DMH all grant equipment purchases and deletions on form DMH-101-01. The DMH-101-01 form and instructions are included in the DMH Service Providers Manual.
6. Ensure that written approval is obtained from DMH and/or the county board of supervisors, depending on the source of funding, before disposition of real and personal property purchased with state and/or county appropriated funds.
7. Ensure that all insurance proceeds or proceeds from the sale of grant inventory be returned to the program for which it was initially purchased.
8. Property and equipment ledgers are periodically reconciled to general ledger accounts.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.7 Policies

C. The fiscal management system of the provider must include a fee policy that:

4. Maintains a current written schedule of rate, charge, and discount policies.
5. Is immediately accessible to individuals served by the program.
6. For community living programs, includes the development, and result in documentation, of a written financial agreement with each individual or parent/ legal representative (of individuals under 18 years of age) entering the program that, at a minimum:

(d) Contains the basic charges agreed upon, the period to be covered by the charges, services for which special charges are made, and agreements regarding refunds for any payment made in advance;
(e) Is prepared prior to or at the time of admission and signed by the individual/parent/legal representative and provided in two (2) or more copies, one (1) copy given to the individual/parent/legal representative, and one (1) copy placed on file in the individual's record; and
(f) Does not relieve the provider of the community living program of the responsibility for the protection of the individual and personal property of the individual admitted to the program for care.

D. All providers must have policies that include/address the following:

1. Non-discrimination based on ability to pay, race, sex, age, creed, national origin or disability;
2. A sliding fee scale;
3. A method of obtaining a signed statement from the individual receiving services indicating that the individual's personal information provided is accurate;
4. All personnel who handle program funds must be bonded to cover risks associated with employee dishonesty or theft; and
5. Insurance that includes liability, fire, theft, disaster and workman's compensation must be obtained and kept current by the provider (unless otherwise provided by law).

C. All ID/DD Waiver providers must have rental/lease/sublease agreements with individuals residing in provider owned living arrangements. These agreements must afford individuals the same rights as the Landlord/Tenant Laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to125 and §89-8-1 to 89-8-1 to 89).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.8 Community Mental Health Centers (DMH/C Providers)

Community Mental Health Centers must submit a plan to DMH when the Regional Commission and/or related organization has accumulated excess surplus funds in excess of 1/2 its annual operating budget stating the capital improvements or other projects that require such surplus accumulation. If the required plan is not submitted within forty-five (45) days of the end of the applicable fiscal year, DMH shall withhold all state appropriated funds from such regional commission until such time as the capital improvement plan is submitted. If the plan is submitted, but not accepted by DMH, the surplus funds will be expended by the regional commission in the local mental health region on housing options for the mentally ill, intellectually/developmentally disabled, substance abusers, children or other mental health or intellectual/developmental disabilities services approved by DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 10.9 Generated Income

A. Accounting records must be maintained on generated income from work contracts that detail dollar amounts and fund utilization.

B. The provider must maintain evidence of prior written authorization from the Director of the Bureau of Intellectual/Developmental Disabilities for utilization of generated income for anything other than supplies needed for subcontracts/products and individual wage payments. The use of generated income must be documented as: enhancing/enriching the program and not being used as part of a required match.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 11: Human Resources

Rule 11.1 Personnel Policies and Procedures

B. The provider must have written personnel policies and procedures that at a minimum:

1. Assure that the hiring, assignment, and promotion of employees shall be based on their qualifications and abilities without regard to sex, race, color, religion, age, irrelevant disability, marital status, or ethnic or national origin
13. Prohibit pre-employment inquiries about the nature of an applicant's disability which does not affect their ability to perform the job
14. Prohibit an employee's salary and work time from being allocated among multiple DMH grants, and potentially among multiple grant recipients, unless approved by DMH in writing. Requests for approval must not exceed one full time equivalent (FTE) position.

B. The written personnel policies must describe personnel procedures addressing the following areas:

13. Wage and salary administration
14. Employee benefits
15. Working hours
16. Vacation and sick leave (includes maternity leave)
17. Annual job performance evaluations. Job performance evaluations must be in writing, and there must be documented evidence that evaluations are reviewed with the employee
18. Suspension or dismissal of an employee, including the employee appeal process
19. Private practice by program employees
20. The utilization (if applicable and certified to do so) of consumers and family members to provide Peer Support Services.

D. Designate staff, with documentation in their respective job description(s), to implement and/or coordinate personnel policies and procedures and to:

4. Maintain personnel records;
5. Disseminate employment information to program staff; and
6. Supervise the processing of employment forms.

D. If a provider uses volunteers, there must be policies and procedures describing, at a minimum, the following:

1. The scope and objectives of the volunteer service (role and activities of volunteers);
2. Supervision of volunteers by staff member in areas to which volunteers are assigned.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.2 Personnel Records

A personnel record for each employee/staff member and contractual employee, as noted below, must be maintained and must include, but not be limited to:

A. The application for employment or resume, including employment history and experience;

B. A copy of the employee's degree and/or transcript;

C. A copy of the current Mississippi license or certification for all licensed or certified personnel;

D. A copy of a valid driver's license, ~~registration~~, and insurance for all designated drivers;

E. For all staff and volunteers, documentation must be maintained that a criminal records background check (including prior convictions under the Vulnerable Adults Act) and child registry check (for staff and volunteers who work with or may have to work with children) has been obtained by the current entity seeking to employ the individual and no information was received that would exclude the employee/volunteer. (See Sections 43-15-6, 43-20-5, and 43-20-8 of the *Mississippi Code of 1972, Annotated*.) For the purposes of these checks, each employee/volunteer must be fingerprinted and fingerprints must be run as a part of the background check; Criminal Records background checks and child registry checks must be completed at least every five (5) years for employees hired after the effective date of the standards while the staff is employed with the agency.

P. Documentation of verification of at least two (2) references. One reference must be a professional reference.

Q. Annual job performance evaluations.

R. Job description.

S. Date of hire.

T. If contractual services are provided by a certified provider, or obtained by a certified provider, there must be a current written contractual agreement in place that addresses, at minimum, the following:
   1. Roles and responsibilities of both parties identified in the agreement
   2. Procedures for obtaining necessary informed consent, including consent for release and sharing of information
   3. Assurances that DMH Operational Standards will be met by both parties identified in the agreement.

4. An annual review of the contractual agreement by both parties.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.3 General Qualifications

To ensure initial and continuing receipt of certification/funding from the DMH or other approved sources, the provider must maintain documentation that staff meets the following qualifications unless otherwise specified herein:

N. One full-time Executive Director who has a minimum of a Master's degree in a mental health or related field with a minimum of three (3) years administrative experience in programs related to mental health, intellectual/developmental disabilities, or substance ~~abuse~~ use disorders services and/or programs OR a minimum of a Bachelor's degree in nursing and current licensure as a Registered Nurse (RN) for DMH/H Providers only that primarily serve as providers of In-Home Nursing Respite Services and Home and Community Supports.

O. Director(s) with overall responsibility for a service, service area(s) (such as Community Services Director, Director of Community Support Services, Director of ID/DD Waiver Support Coordination, Program Director for Adult and Children's Partial Hospitalization, Day Treatment, Treatment Foster Care) or multiple services provided at/from a single location must have at least a Master's degree in mental health or intellectual/developmental disabilities, or a related field and either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the service and population being served). A Registered Nurse may be employed as the Director for DMH/H Providers only that primarily serve as providers of In-Home Respite and Home and Community Supports.

P. In addition to the requirements outlined in Rule 11.3, B. Directors of Treatment Foster Care Programs must also have at least one (1) year of experience in administration or supervision of a mental health or related program/service.

Q. Supervisor(s) with predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services at a single location for such areas as Psychosocial Rehabilitation Services, Day Support Services etc., must have at least a Bachelor's degree in a mental health, intellectual/developmental disabilities, or a related field, and be under the supervision of an individual with a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the service and population being served).

R. Medication evaluation and monitoring, the initial evaluation, prescribing of medications, and regular/periodic monitoring of the therapeutic effects of medication prescribed for mental health purposes are provided by:

4. A Board-certified or Board-eligible psychiatrist licensed by the Mississippi Board of Medical Licensure
5. A psychiatric/mental health nurse practitioner licensed by the Mississippi Board of Nursing or
6. If documented efforts, including efforts to work with the Department of Health to recruit a licensed psychiatrist through the J-I Visa or Public Health Service Program during the certification period are unsuccessful, psychiatric services may be provided by other physician(s) licensed by the Mississippi Board of Medical Licensure.

S. Medical services are provided by a psychiatrist or other physician licensed by the Mississippi Board of Medical Licensure.

T. Nursing services are provided by a Registered Nurse licensed to practice in Mississippi or a Licensed Practical Nurse as allowed in the Mississippi Nursing Practice Act and Rules and Regulations.

U. Psychological services are provided by a psychologist licensed by the Mississippi Board of Psychology.

V. Therapy or Counseling services are provided by an individual with at least a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist, Intellectual/Developmental Disabilities Therapist, or Addictions Therapist (as appropriate to the service and population being served).

W. In addition to the requirements outlined in Rule 11.3.I, the Mental Health Therapist in Treatment Foster Care programs, must have at least one (1) year of experience and/or training in working directly with children/youth with behavioral/emotional disturbance.

X. All Day Treatment Specialists providing Day Treatment Services for children and youth must have a Master's degree in a mental health or related mental health field and (1) a professional license or (2) a DMH credential as a Mental Health Therapist.

Y. Therapeutic Services provided as a component of an Adolescent Offender Program (AOP) can be provided by an individual with a Master's Degree in a mental health or related field (to include criminal justice) and a DMH credential as a Mental Health Therapist with designation and scope of practice limited to AOP.

Z. Community Support Services, ~~including ID/DD Waiver Support Coordination Services~~, are provided by an individual with at least a Bachelor's Degree in a mental health, intellectual/developmental disabilities, or related field and at least a DMH ~~Case Management/~~Community Support Specialist Credential. Community Support Services

can also be provided by DMH Credentialed Therapists (MH, IDD and Addictions as appropriate to the population being served) and individuals with an appropriate professional license~~. ID/DD Waiver Support Coordination can also be provided by a Registered Nurse.~~

AA. ~~Community Support Services provided as a component of an Adolescent Offender Program (AOP) can be provided by an individual with a Bachelor's Degree in a mental health or related field (to include criminal justice) and a DMH credential as a Community Support Specialist with designation and scope of practice limited to AOP.~~

N. O. ~~Treatment~~ Therapeutic Foster Care Specialist(s) must have at least a Bachelor's Degree in a Mental Health or related field and at least one (1) year of documented experience and/or training in working with children with special behavioral/emotional needs and their families/other caregivers.

O. ~~P.~~ Teachers and Education Specialists have a Master's degree or a Bachelor's degree in Special Education, as required, with training in mental health, intellectual/developmental disabilities, or a related field, and possess certification by the MS Department of Education appropriate to the service area for which they are assigned.

P. ~~Q.~~ All staff providing Peer Support Services (i.e. Certified Peer Specialist) must possess at least a high school diploma or GED equivalent, self-identify as a current or former consumer of mental health services, ~~demonstrate a minimum of six (6) months in self-directed recovery within the last year~~, or self-identify as first degree family member, parent or primary caregiver. For young adults ages sixteen to twenty (16-20) years, peer support specialists must be enrolled and attending school or in the process of obtaining a Test of General Education Development (GED). All staff must successfully complete the DMH approved Certified Peer Specialist training and certification exam to become a Certified Peer Support Specialist.

Q. ~~R.~~ Wraparound Facilitators must hold a minimum of a Bachelor's Degree in a mental health, intellectual/developmental disabilities, or related field ~~high school diploma or GED equivalent,~~ complete the "Introduction to Wraparound" 3-day training and subsequent trainings. Wraparound Facilitators must be under the supervision of a Master's level staff who has also completed the "Introduction to Wraparound" 3-day training.

R. ~~S.~~ All direct care staff such as Aides, House Parents, House Managers, On-Site Community Living Managers, Direct Care Workers, Direct Support Professionals, Work Trainers, Production Assistants, Day Treatment Assistants, support staff in Psychosocial Rehabilitation, Senior Psychosocial, and Day Support Programs, Day Services-Adult staff, Home and Community Support Services staff, Job Coaches, etc. must have at least a high school diploma or equivalent (GED).

S. ~~T.~~ All support staff (responsible for indirect services to individuals receiving services) such as Secretary, Bookkeeper, Office Clerk, Cook, etc., must have any combination of

education and experience which is acceptable to the certified provider, and is equivalent to a high school diploma or GED.

X. ~~U.~~ Specialists such as Audiologists, Speech/Language Pathologists, Occupational Therapists, Dieticians, Physical Therapists, etc., must meet the educational requirements of and be licensed by their respective licensing authority in Mississippi.

Y. ~~V.~~ Individuals serving as Qualified ~~Developmental~~ Intellectual Disabilities/~~Mental Retardation~~ Professionals (QIDP ~~QMDDP/QMRP~~) must have at least a Bachelor's degree in a human services field and one year of experience in direct service with individuals with developmental disabilities.

Z. ~~W.~~ Individuals ~~providing~~ writing Job Discovery Profiles for IDD Waiver Services must have at least a Bachelor's Degree in a mental health/ intellectual/developmental disabilities, or related field, and be under the supervision of an individual meeting the requirements of Rule B. Individuals ~~providing~~ writing Job Discovery ~~Services~~ Profiles must have completed training in Customized Employment approved by the DMH prior to service provision. Observation and/or participation in Job Discovery activities can be conducted by direct care staff meeting the requirements of 11.3.S.

W. ~~X.~~ Family members are prohibited from providing services to another family member with the exception of Home and Community Supports, In-Home Respite, and Host Home Services. ~~Approval for a family member to provide Home and Community Support Services or Host Home Services to another family member must be approved by the DMH Review Committee.~~

CC. Targeted case management for individuals with SMI or SED must be provided by, at a minimum, a licensed social worker (LSW) with two (2) years of experience in mental health, a registered nurse (RN) with two (2) years of experience in mental health, or an individual who meets the qualifications to provide therapy or counseling services as stated in letter I above.

DD. Targeted case management for individuals with IDD must be provided by a Licensed Social Worker (LSW) or an individual with at least a Bachelor's Degree in an intellectual/developmental disabilities, or related field; meet the requirements of a Qualified Intellectual Disabilities Professional (QIDP) as well as having at least two (2) years of experience working with people with IDD and have completed the required Person Centered Planning training (both Person Centered Thinking and Person Centered Facilitation) as set forth by the DMH prior to becoming responsible for the development of the Plan of Services and Supports.

EE. ID/DD Waiver Support Coordination is provided by an individual with at least a Bachelor's Degree in an intellectual/developmental disabilities, or related field. Support Coordination can also be provided by DMH Credentialed Therapists, as appropriate to the population being served or individuals with an appropriate professional license. ID/DD Waiver Support Coordination can also be provided by a Registered Nurse with at

least one (1) year of experience working with people who have intellectual/developmental disabilities.

FF. All individuals providing Supported Employment Services to individuals with a serious mental illness must have, at a minimum, a Bachelor's Degree in mental health, vocational rehabilitation, social services or business. Individuals must be proficient or receive training in the development of a career profile, employment plans, job development, career development, job search and Social Security benefits.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.4 Qualifications for Behavior Support and Crisis Intervention Provided through the ID/DD Waiver

C. ID/DD Waiver Behavior Consultants must be a Licensed Psychologist, Licensed Professional Counselor, Licensed Certified Social Worker, Board Certified Behavior Analyst ®, or have a Master's degree in a field related to working with individuals with intellectual and developmental disabilities who require behavior support and have at least two (2) years of documented experience conducting Functional Behavior Assessments and developing and implementing Behavior Support Plans. ~~The Behavior Consultant must be supervised by a professional licensed clinician or person who holds certification as a Board Certified Behavior Analyst® (BCBA®) if he/she is not professionally licensed or does not hold a DMH credential as a CMHT or CIDDT.~~ The Behavior Consultant must hold at least a CMHT or CIDDT DMH credential. The Behavior Consultant must be Mandt certified or hold another nationally recognized credential approved by DMH.

D. ID/DD Waiver Behavior ~~Specialists~~ Interventionists must have at least a ~~Master's~~ Bachelor's Degree in a field related to working with individuals with intellectual and developmental disabilities who require behavior services and have at least two (2) years of documented experience working with individuals who have intellectual and developmental disabilities. The Behavior ~~Specialist~~ Interventionist must be Mandt certified or hold another nationally recognized credential approved by DMH. The Behavior ~~Specialist~~ Interventionist must be supervised/monitored by a Behavior Consultant (as defined in Rule 11.4 A).

E. ~~ID/DD Waiver Behavior Interventionists must have at least a Bachelor's Degree in a field related to working with individuals with intellectual and developmental disabilities who require behavior support and have at least two (2) years of documented experience working with individuals who have intellectual and developmental disabilities. The Behavior Interventionist must be Mandt certified or hold another nationally recognized credential approved by DMH. The Behavior Interventionist must be supervised by a Behavior Specialist (as defined in Rule 11.4 B).~~

D. D. ID/DD Waiver Crisis Intervention providers must have a team that includes:

1. A Licensed Psychologist
2. A director (as defined in Rule 11.3 B) who also has specialized training in crisis intervention ~~as specified/approved by the DMH Behavior Services Oversight Team~~. The Crisis Intervention Director must be Mandt certified or hold another nationally recognized credential approved by DMH.
3. A QDDP who is under the supervision of an individual with a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has at least two (2) years of documented experience working with individuals who have intellectual and developmental disabilities. The QDDP must be Mandt certified or hold another nationally recognized credential approved by DMH.
4. Direct support staff (as defined in 11.3 S) with specialized training in crisis intervention ~~as specified/approved by the DMH Behavior Services Oversight Team~~. The direct support staff must be Mandt certified or hold another nationally recognized credential approved by DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.5 Qualifications for Providers of Substance Use Disorders Services ~~Abuse Prevention and Treatment/Rehabilitation Services employed after January 1, 2011~~

J. Directors/coordinators of all alcohol and drug treatment or prevention programs must have at least: (1) a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field (2) a professional license, ~~or~~ hold a DMH credential as a Certified Mental Health Therapist or DMH Certified Addictions Therapist, or a professional substance use disorder credential approved by DMH, and two (2) years of experience in the field of ~~alcohol and other drug disorders treatment/prevention~~ substance use disorder treatment/prevention. Staff who self-identify as ~~are~~ in recovery ~~from chemical dependency~~ must have a minimum of one (1) year of sustained recovery.

K. Support staff employed in ~~Alcohol and Other Drug Disorders~~ Substance Use Disorder Residential Programs who ~~are~~ self-identify as in recovery must have a minimum of six (6) months of sustained recovery.

L. ~~D.~~ Directors of Prevention Services must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field, and a minimum of two (2) years of experience in the treatment/prevention of substance ~~addiction/abuse~~ use disorders. Staff ~~For individuals~~ who ~~are~~ self-identify as in recovery ~~from chemical dependency,~~ must have a minimum of one (1) year of sustained recovery ~~is required~~.

M. ~~C. Alcohol and Other Drug Disorders~~ Prevention Specialists must have at least a Bachelor's degree. ~~For individuals~~ Staff who ~~are~~ self-identify as in recovery ~~from chemical dependency,~~ must have a minimum of one (1) year of sustained recovery ~~is required~~.

E. ~~Alcohol and Other Drug Disorders~~ Substance Use Disorders Outpatient Therapists~~/Counselors~~ including Intensive Outpatient Treatment Therapists, must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field and a (1) professional license or (2) hold a DMH credential as a Certified Mental Health Therapist or DMH Certified Addictions Therapist. ~~For individuals~~ Staff who ~~are~~ self-identify as in recovery ~~from chemical dependency,~~ must have a minimum of one (1) year of sustained recovery ~~is required~~.

F. All Recovery Support Staff must have at least a high school diploma or GED. These individuals must also successfully complete ~~an alcohol and other drug treatment~~ a substance use disorder services certification program approved by DMH within thirty-six (36) months of the date of employment. ~~For individuals~~ Staff who self-identify as ~~are~~ in recovery ~~from chemical dependency,~~ must have a minimum of six (6) months of sustained recovery ~~is required~~.

G. ~~Alcohol and Other Drug Disorders Chemical Dependency Unit and~~ Residential Program counseling staff must have at least a Bachelor's degree in a mental health or a related behavioral health field. These individuals must also successfully complete ~~an alcohol and other drug~~ a substance use disorders ~~treatment~~ certification program approved by DMH within thirty-six (36) months of the date of employment. ~~For individuals~~ Staff who ~~are~~ self-identify as in recovery ~~from chemical dependency,~~ must have a minimum of one (1) year of sustained recovery ~~is required~~.

H. Providers certified as DMH/C that provide Medicaid-reimbursed services: individual therapy, family therapy, group therapy, multi-family therapy and Individual Service Plan review to individuals with a substance abuse diagnosis must have at least a Master's degree in a mental health or related behavioral health field and (1) have a professional license or (2) a DMH credential as a Mental Health Therapist or (3) DMH credentials as Certified Addictions Therapist.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.6 Qualifications for Programs of Assertive Community Treatment (PACT)

A. Team Leader: The team leader must have at least a Master's degree in nursing, social work, psychiatric rehabilitation or psychology, or is a psychiatrist. The team leader must be professionally licensed or have DMH credentials as a Certified Mental Health Therapist.

B. Psychiatrist/Psychiatric Nurse Practitioner: A psychiatrist/psychiatric nurse practitioner, who work on a full-time or part-time basis, must meet applicable licensure requirements of state boards.

C. Registered Nurse: The registered nurse must be licensed and in good standing with the MS Board of Nursing.

D. Master's Level Mental Health Professionals: Mental health professionals have: 1) professional degrees in one of the core mental health disciplines; 2) clinical training including internships and other supervised practical experiences in a clinical or rehabilitation setting; and 3) clinical work experience with persons with severe and persistent mental illness. They are licensed or certified and operate under the code of ethics of their professions. Mental health professionals include persons with Master's or Doctoral degrees in nursing, social work, rehabilitation counseling, or psychology; Diploma, Associate, and Bachelor's degree nurses (i.e., registered nurse); and registered occupational therapists.

E. Substance ~~Abuse~~ Use Disorders Specialist: A mental health professional with training and experience in substance ~~abuse~~ use disorders assessment and treatment.

F. Employment Specialist: A mental health professional with training and experience in rehabilitation counseling.

K. Peer Specialist: At least one FTE Certified Peer Support Specialist. Peer Support Specialists must be fully integrated team members.

L. Remaining Clinical Staff: The remaining clinical staff may be Bachelor's level and paraprofessional mental health workers. A Bachelor's level mental health worker has a Bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A paraprofessional mental health worker may have a Bachelor's degree in a field other than behavioral sciences or have a high school diploma and work experience with adults with severe and persistent mental illness or with individuals with similar human-service needs. These paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.

I. Program Assistant: Assistants must have at least a high school diploma or a GED and be at least twenty-one (21) years old.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 11.7 Multidisciplinary Staff at ~~CMHCs (~~DMH/C and DMH/P Providers)

Community Mental Health Center providers (certified under the DMH/C option) must have a multidisciplinary staff, with at least the following disciplines represented:

B. A psychiatrist who is board certified or board eligible and licensed to practice medicine in Mississippi. (Available on a contractual, part-time or full-time basis).

B. A psychologist licensed to practice in Mississippi. ~~and certified by the Mississippi Board of Psychology to perform Civil Commitment Examinations~~ (available on a contractual, part-time or full-time basis).

C. A full-time or full-time equivalent registered nurse.

D. A full-time or full-time equivalent Licensed Master Social Worker, Licensed Professional Counselor (LPC), or Licensed Marriage and Family Therapist (LMFT).

E. A full-time or full-time equivalent business manager who is capable of assuming responsibility for the fiscal operations of the program.

F. A full-time or full-time equivalent records practitioner or designated records clerk who is capable of assuming responsibility for the supervision and control of all center records.

G. An individual with at least a Master's degree in a mental health or related field on a full-time basis to supervise children's mental health services. This person must have administrative authority and responsibility for children's mental health services. This person cannot have any direct service responsibilities.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

~~Rule 11.8 Providers of Peer Support Services~~

~~Unless otherwise specified herein, all individuals employed must meet all of the minimum qualifications listed below for providers of Peer Support Services:~~

~~A. Individuals must be a current or former consumer or first-degree family member of an individual who has received treatment for and self-identifies as a consumer or former mental health consumer.~~

~~B. Individuals must possess a high school diploma or GED equivalent.~~

~~C. Individuals must have demonstrated a minimum of six (6) months, preferably twelve (12) months, in self-directed recovery.~~

~~D. Individuals must be a DMH Certified Peer Support Specialist who works under the supervision of a mental health professional who has completed a DMH approved supervisory training.~~

~~E. Certified Peer Support Specialists must provide documentation of successful completion of at least one of the DMH recognized peer training programs, that is designed to increase the knowledge of the Certified Peer Support Specialist about the population he/she will be supporting.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

~~Rule 11.9 Staffing/Qualifications for Opioid Treatment Programs Utilizing Methadone~~

~~A. An Opioid Treatment Program must employ sufficient and qualified staff to meet the treatment and support needs of the population served. Services must be provided by an interdisciplinary team, all of whom are properly licensed, registered, or certified by the appropriate authority in accordance with Mississippi law. At a minimum, the staff must include:~~

~~1. A licensed physician;~~
~~2. A Registered Nurse;~~
~~3. A Licensed pharmacist, and~~
~~4. Licensed psychologist/counselor/social worker, licensed/certified mental health therapist (specialized in alcohol/drug addiction services) who must be on-site during all hours of operation. The counselor to individual ratio cannot exceed 1:75 (one (1) counselor per seventy five (75) individuals served by the program).~~

~~C. An Opioid Treatment Program must designate a medical director/staff physician who is responsible for administering and supervising all medical services performed by the program. The medical director/staff physician must be a physician licensed in the State of Mississippi. He/she must be on site as needed to complete all medical needs in accordance with standard medical practice and available by phone as needed.~~

~~D. An Opioid Treatment Program must employ at least one full-time Registered Nurse (RN) for the first 100 or fewer individuals. In addition to the one full-time registered nurse additional registered nurses must be maintained so as to provide nursing services at least one (1) hour per week per five (5) individuals enrolled over 100 individuals. (For example a program serving 150 individuals would have one full-time RN and an additional ten (10) hours per week of RN time from another RN on staff). Nursing functions may be supplemented by a licensed practical nurse, if a registered nurse or physician is on duty. All nursing services provided must be in compliance with the Mississippi Nursing Practice Act (Section 73-15-1 et. seq. of the Mississippi Code of 1972 as Annotated) and current rules and regulations promulgated by the Mississippi State Board of Nursing.~~

~~E. A person may hold more than one staff position within the facility if that person is qualified to function in both capacities, and the required hours for each job are separate and apart for each position.~~

~~F. All Opioid Treatment Programs must provide availability of staff seven (7) days a week, twenty-four (24) hours a day. A record of the on-call schedule must be maintained and the individuals must be informed of how to access the on-call staff; therefore, a signed statement by the individual must be maintained in the individual's record. The on-call staff must be available at all times for emergencies of the individuals served. The on-call staff must have access to pertinent individual information including dosage levels.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

Part 2: Chapter 12: Training/Staff Development

Rule 12.1 General Orientation

E. All new employees and volunteers/interns must attend a General Orientation program developed by the agency or receive the orientation information via a DMH approved on-line training program (such as Essential Learning or the College of Direct Support). General Orientation must be provided/completed within thirty (30) days of hire/placement, except for direct service providers and direct service interns/volunteers. All direct service staff must complete all required orientation prior to contact with individuals receiving services and/or service delivery.

F. At a minimum, General Orientation must address the following areas:

12. Overview of the agency's mission and an overview of the agency policies and procedures
13. DMH Operational Standards (as applicable to services provided)
14. DMH Record Guide and Record Keeping (as applicable to services provided)
15. Basic First Aid
16. CPR
6. Infection Control
   (c) Universal Precautions
   (d) Hand-washing
7. Workplace Safety
   (e) Fire and disaster training
   (f) Emergency/disaster response
   (g) Serious incident reporting
   (h) Reporting of suspected abuse/neglect (including signed acknowledgement of reporting responsibilities)
8. Rights of Individuals Receiving Services
9. Confidentiality
10. Family/Cultural Issues and Respecting Cultural Differences
11. Basic standards of ethical and professional conduct
    (a) Drug Free Workplace
    (b) Sexual Harassment
    (c) Acceptable professional organization/credentialing standards and guidelines as appropriate to discipline (i.e., ACA Code of Ethics, Social Work Code of Ethics, APA Ethics Code) - *Direct service providers only*
12. Principles of positive behavior support
13. Principles of behavior support (physical and verbal)

~~12. Accurate gathering, documentation, and reporting of data elements outlined in the current version of DMH's Manual of Uniform Data Standards for staff responsible for data collection and entry. Each data element and their respective codes must be addressed.~~

G. In addition to the requirements of 12.1 A and B, all direct service staff must be certified in CPR prior to contact with individuals receiving services and/or service delivery.

H. ~~C.~~ In addition to the requirements of 12.1 A and B, ~~12.2, 12.3, 12.4, and 12.5,~~ Opioid Treatment Programs must include the following in general orientation:

1. Overdose management and other emergency procedures;
2. Clinical and pharmacotherapy issues;
3. Special populations to include women and seniors;
4. ~~Behavioral management (physical and verbal);~~
5. Poly-drug addiction; and,
6. HIV/AIDS, TB, and other infectious diseases.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.2 Staff Training Plans

B. Providers must develop a Staff Training Plan specific to each position classification as listed below. Each Staff Training Plan must be based on job responsibilities, program/position requirements, and identified staff needs. The Staff Training Plan must be reviewed annually for changes and/or updates and should be available for review by DMH staff. Position specific training must be provided within ninety (90) days of hire and consist of a minimum of twenty (20) hours of training (medical personnel excluded – i.e., psychiatrists, nurses, etc.). The following position classifications must be addressed:

1. Direct service provider (i.e., therapist, community support specialist, program assistants)
2. Administrative/support staff (i.e., office manager, medical records technician, accounting staff)

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.3 Continuing Education Plans

B. Providers must develop an Annual Continuing Education Plan specific to each position classification as listed below. Each Continuing Education Plan should be based on job responsibilities, credentialing requirements, and identified staff needs. The Continuing Education Plan must be reviewed annually for changes and/or updates and must be available for review by DMH Staff. The following position classifications and required minimum hours of continuing education must be addressed:

6. Direct service provider (i.e., community support specialist, program assistants). A minimum of thirty (30) continuing education hours every two (2) years must be completed by all individuals in this position class.
   (a) IDD direct service providers who do not hold a license or DMH Credential, a minimum of fifteen (15) hours per year of continuing education is required.

7. DMH Credentialed Therapists must complete a minimum of thirty (30) continuing education hours every two (2) years.
8. Professionally licensed staff (i.e., Psychologists, social workers, etc.) must adhere to the continuing education requirements of their respective state licensing boards.
9. Administrative/support staff (i.e., office manager, medical records technician, accounting staff).
10. Medical personnel (i.e., psychiatrist, nurses) - as required by state licensing boards.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.4 ~~General~~ Required Components of Staff Training Plans and Continuing Education Plans

G. At a minimum, Staff Training Plans and Continuing Education Plans must address the following areas:

8. Crisis ~~Prevention and I~~intervention and prevention
9. CPR Certification for all direct service staff
10. ~~2.~~ Person Centered ,Recovery~~/Resiliency~~ Oriented Systems of Care (~~as applicable for population being served~~ Mental Health Providers and Substance Use Disorders Providers)
11. ~~3.~~ Person-Centered Planning (~~as applicable to population being served~~ Intellectual/ Developmental Disabilities Providers)
12. ~~4.~~ Concepts of Wraparound Service Delivery (~~as applicable to population being served~~ Children and Youth Mental Health Providers)
13. ~~5.~~ Accurate gathering, documentation and reporting of data elements outlined in the current version of the DMH's Manual of Uniform Data Standards for staff responsible for data collection and entry.
14. Positive behavior support concepts (as applicable to the population being served)

H. All staff is required to participate in orientations, program/position specific training, staff development opportunities, and other meetings as required by DMH for their position specification.

I. Documentation of training that individual staff has received must be included in individual training and/or personnel records. This documentation can include certificates of completion for DMH approved on-line learning. If training is provided in person or through other means, the documentation must include:

6. Name of training
7. Instructor's name and credentials
8. Date of training
9. Length of time spent in training
10. Topics covered
11. ~~Learning objectives.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 12.5 Skills and Competencies

A. For staff ~~that works~~ working with individuals receiving services, orientation, training and continuing education must focus on skills and competencies directed towards the intellectual, developmental, behavioral and health needs of the individuals being served. ~~Additionally, staff must be able to demonstrate the skills and techniques necessary to administer interventions to manage inappropriate behavior of individuals served and the skills necessary to implement the individual plans for individuals being served.~~

B. For all staff working with individuals receiving services in all day programs and in all residential community living programs, training and certification in a nationally recognized and DMH approved technique for managing aggressive or risk-to-self behaviors to include verbal and physical de-escalation is required. (This does not apply to Alzheimer's Day Services.)

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 13: Health and Safety

Rule 13.1 Compliance

All DMH Certified Providers, regardless of type, must follow the rules and standards outlined in this Chapter. Supported Living, Supervised Living, Shared Supported Living and Host Homes programs that are not owned/operated by ~~an agency or~~ a certified provider ~~may be~~ are exempt from some or all of the procedures and standards outlined in this part as noted. Additionally, Therapeutic Foster Care Programs and Therapeutic Group Homes licensed by the MS Department of Human Services are exempt from the rules outlined in this Chapter.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.2 Local Fire, Health and Safety Codes

B. All programs must meet state and local fire, health, and safety codes with documentation maintained at each site, as follows:

1. ~~A. Programs~~ Each program site must be inspected and approved by appropriate local and/or state fire, health and safety agencies at least annually (within the anniversary month of the last inspection), and there must be written records at each site of fire and health inspections. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

2. ~~B.~~ Safety inspections conducted by reputable fire safety agencies are permissible only for ~~homelike~~ community living program settings in lieu of local or state inspection(s). (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

3. ~~C.~~ Crisis Stabilization Units and Primary Substance Abuse Rehabilitation and Treatment Programs with certified capacities of sixteen (16) or more participants shall obtain a Food Service Permit from the Mississippi State Department of Health.

4. ~~D.~~ Crisis Stabilization Units and Primary Substance Abuse Rehabilitation and Treatment Programs with certified capacities of sixteen (16) or more participants shall meet the requirements as set forth in the Residential Inspection Report issued by the Mississippi State Department of Health.

5. ~~E.~~ Documentation by appropriate fire and health authorities that noted citations have been corrected must be maintained at each site. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

6. ~~F.~~ Program~~s~~ sites with an existing sprinkler system must have annual inspection by a licensed company or the local fire authorities. There must be documentation of

annual inspection by a licensed company. (Exclusion: Supported Living programs that are not owned/operated by an agency or certified provider, Shared Supported Living programs and Host Homes.)

7. ~~G. Programs~~ Each program site must provide evidence and documentation of a systematic pest control program. This documentation must be maintained at each site. For apartment settings, the provider must show documentation that the apartment complex provides pest control. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

8. ~~H. Programs~~ Each program site must have an established method of scheduled fire equipment inspection that includes: (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

   (a) ~~1.~~ An annual inspection by an outside source (i.e., fire marshal, fire department representative, fire/safety company) that results in a dated tag on each piece of equipment inspected; and
   (b) ~~2. A monthly inspection by a staff person to verify that equipment is properly charged that is documented in a log or on the extinguisher itself that includes the extinguisher serial number and location plus the date and initials of the person completing the inspection.~~

12. ~~I. Programs~~ Each program site must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the facility/home, and document that all fire extinguishers are properly maintained and serviced. Facilities/homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

13. ~~J.~~ Each program site must have, at minimum, operable fire extinguishing equipment and alarms/detectors located throughout the ~~facility~~ site in all areas where conditions warrant (i.e., flammable storage areas, kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

14. ~~K.~~ Each program site must have, at a minimum, operable carbon monoxide detectors located in any building where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.3 Exits

J. Diagrams of escape routes must be easy to read from a short distance and posted in highly visible locations throughout the environment, clearly indicating where a person is located in relation to the nearest exit(s). In lieu of posted escape routes, providers of Supervised Living, Supported Living, Shared Supported Living, and Host Home Services, must document training~~/drills~~ that prepare an individual to exit the location in the event of emergency. Training must take place upon admission and at least quarterly thereafter. This documentation must be maintained on site.

K. Every exit shall be clearly visible, or the route to reach every exit shall be conspicuously indicated. Each means of egress, in its entirety, shall be arranged or marked so that the way to a place of safety is indicated in a clear manner. (Exclusion: Supervised Living, Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

L. Two (2) means of exit per service area must be provided which are readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition. (Exclusion: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

M. Exits must be marked by a lighted sign with lettering, at a minimum, six (6) inches in height on a contrasting background in plain lettering that is readily visible from any direction of exit access (excludes Supervised, Supported Living, and Host Home Services). The signs must be lighted at all times. The illuminated lights must have battery backup in order to be readily visible in the event of electrical failure (facilities with backup generator systems are excluded from the battery backup requirement). ~~The system must be tested on an established schedule with documentation of testing maintained onsite.~~ (Exclusion: Supervised Living, Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

N. Any accessible window(s) must be operable from the inside without the use of tools and must provide a clear opening of not fewer than twenty (20) inches in width and twenty-four (24) inches in height (with the exception of CSUs and Supported Living, Shared Supported, and Host Homes sites that are not owned/operated by a certified provider).

O. No door in any path of exit, or the exit door itself, may be locked when the building is occupied unless an emergency system is in place ~~in the facility~~ that will allow the door to unlock in an emergency (Exclusion: Supporting Living Services that are not owned/operated by a certified provider, Supervising Living, Shared Supported Living ~~in apartment settings~~, and Host Home Services).

P. Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met: (Exclusion: Supporting Living Services that

are not owned/operated by a certified provider, Shared Supported Living, Supervised Living ~~in apartment settings~~, and Host Home Services):

1. A readily visible, durable sign in letters not less than one (1) inch high on contrasting background that reads as follows: THIS DOOR TO REMAIN UNLOCKED WHEN THE BUILDING IS OCCUPIED
2. The locking device is one that is readily distinguishable as locked.
3. Each staff member inside the building must have a key on their person when the egress door is locked.
4. There may only be one locked door per means of egress.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.4 Safe and Sanitary Conditions

D. The interior and exterior of each ~~facility~~ program must be maintained in a safe and sanitary manner. Furnishings must be kept clean, well-kept and in good repair.

E. All programs must have operable hot water. The water temperature in all water heaters in facilities providing services directly to individuals enrolled in DMH programs must be set at no higher than one hundred twenty degrees (120 degrees) Fahrenheit and no lower than one hundred (100) degrees Fahrenheit. ~~A temperature measurement taken monthly at each fixture in community living programs, Crisis Stabilization Units and substance abuse residential treatment programs must be entered into a log and signed and dated by the person making the entry. A temperature measurement taken quarterly at each fixture in all other service/program types (i.e. outpatient service locations, day program locations) must be entered into a log and signed and dated by the person making the entry.~~ (Exception: Supported Living and Host Homes.)

F. Emergency lighting systems (appropriate to the setting) must be located in corridors and/or hallways and must provide the required illumination automatically in the event of any interruption of normal lighting such as failure of public utility or other outside power supply, opening of a circuit breaker or fuse, or any manual act which disrupts the power supply. ~~Emergency lighting systems and egress lighting systems must be tested for a continuous length of at least thirty (30) seconds per month. and one continuous ninety (90) minute test per year. Providers must maintain documentation of testing, including the date of the test and the signature of the person conducting the test.~~ (Exception: Supervised Living, Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

F. All DMH certified service locations must conduct a Safety Review of the premises on a monthly basis. A Safety Review Log must be completed and kept on site. Staff must date and initial when each item on the Safety Review Log has been checked. The Safety Review Log must include;

8. All fire extinguishers. Staff is to verify each extinguisher is properly charged and mounted. Each extinguisher must be listed separately by location in the facility and include the serial number. Fire extinguishers mounted in agency vehicles are to be included in the review.
9. All fire/smoke detectors. Staff is to verify each detector is working properly by testing the audible signal. Each detector is to be listed separately by location in the facility.
10. All carbon monoxide detectors (if applicable.) Staff is to verify each detector is working properly by testing the audible signal. Each detector is to be listed separately by location in the facility.
11. Lighted exit signs. Staff is to verify each sign is working properly by interrupting the power supply to the sign. Each sign is to be listed separately by location in the facility.
12. Hot water fixtures. Staff is to verify the hot water at each fixture in the facility measures between 100 and 120 degrees Fahrenheit. Each fixture is to be listed separately by location in the facility.
13. Emergency lights. Staff is to verify each emergency light is working properly by interrupting the power supply to the light for at least thirty (30) seconds. Each emergency light is to be listed separately by location in the facility.
14. Safe and sanitary conditions. Staff is to verify the program's environment is safe and sanitary through visual inspection.

G. ~~D.~~ Any ~~facility~~ program that has a kitchen used by individuals receiving services must be designed and equipped to facilitate preparing and serving meals in a clean and orderly fashion. At a minimum, the following equipment must be provided: (Exception: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

1. Two-compartment sink or an automatic dishwasher and single sink (Except in single occupancy living situations, in which case a single compartment sink is acceptable)
2. Adequate supply of dishes, cooking utensils, etc.
3. Adequate refrigeration facilities
4. Adequate space for the storage of food supplies. (No food supplies may be stored on the floor.)
5. Approved fire extinguishing equipment and alarms/smoke detectors which show evidence of fire department inspection placed strategically to allow detection of smoke/fire in the kitchen.

F. Restroom door locks must be designed to permit the opening of the locked door from the outside. (Exception: Supported Living programs that are not owned/operated by a certified provider, Shared Supported Living programs and Host Homes.)

G. All supplies, including flammable liquids and other harmful materials, must be stored to provide for the safety of the individuals ~~enrolled~~ receiving services and the staff working in the program.

H. Each ~~facility~~ program must provide floor space for the lounge/dining/visitation area(s) that is easily accessed/exited in case of emergency.

M. All ~~facilities~~ programs must have operational utilities (water/sewer, air conditioning/heat, electricity). ~~Facilities must also have a written plan of action in place at each site in case utilities fail. The plan must be readily available for review~~

N. Each site must have a written plan of action in place in case utilities fail. The plan must be readily available for review. (Exception: Supported Living, Shared Supported programs that are not owned/operated by a certified provider and Host Homes.)

O. ~~I.~~ No stove or combustion heater may be so located as to block escape in case of fire arising from a malfunction of the stove or heater.

P. ~~J.~~ No portable heaters are allowed in service areas or bedrooms.

Q. ~~K.~~ DMH may require additional square footage in any ~~facility/~~program in order to accommodate the needs of the individuals in the ~~facility/~~program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.5 Accessibility

J. ~~Facilities~~ All program sites and services must be in compliance with Section 504 of the Rehabilitation Act of 1973, as amended, and the Americans with Disabilities Act (P.L. 101-336). ~~Based on the needs of the individuals served in each residence, Supervised Living Supported Living, and Host Home Services must make necessary modifications as outlined in 13.5 B-G and Rule 13.6. Services cannot be denied based on the need for modifications.~~

K. For Supervised Living, Share Supported Living, and Host Homes, and based on the needs of the individuals served in each residence, the provider must make necessary modifications as outlined in 13.5 B-G and Rule 13.6. Services cannot be denied based on the need for modifications. (Exclusion: Supported Living programs that are not owned/operated by a certified provider).

L. New construction of program sites or renovation of existing locations must be in compliance with ADA requirements.

M. ~~B.~~ The clear width of doorways when the door is in the full open position must not be fewer than thirty-two (32) inches.

N. ~~C.~~ At least one restroom ~~in~~ at the ~~facility~~ site must be accessible to individuals with physical disabilities with either one accessible restroom for each sex or one (1) accessible unisex restroom being acceptable. Additionally, ~~non-community living~~ day programs serving individuals with ID/DD must have adequate private changing facilities.

O. ~~D.~~ The accessible restroom stall must have grab bars behind and beside the toilet and on the wall nearest the lavatory/sink.

P. ~~E.~~ All faucets, soap and other dispensers, and hand dryers (if present) must be within reach of someone using a wheelchair and usable with one closed fist.

Q. ~~F.~~ All doors, including stall doors in the restroom, must be operable with a closed fist from the inside. ~~the exit~~

R. ~~G.~~ Any ~~facility~~ program that has drinking fountains must have at least one fountain that is ADA accessible.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.6 Stairs

F. Doors opening onto stairs must have a landing, at a minimum, the width of the door.

G. Minimum head room on stairs and ramps to clear all obstructions must be six feet and eight inches (6' 8").

H. Stairs in the program ~~facility(ies)~~ sites must have the following dimensions:

1. Stair width must be at least thirty-two (32) inches
2. Minimum tread depth of each step of the stairs must be at least nine (9) inches
3. Maximum height of risers in each step must not exceed eight (8) inches

I. Guards and handrails must be provided on both sides of all stairs and ramps rising more than thirty (30) inches above the floor or grade.

1. Guards and handrails must continue for the full length of the ramp or stairs
2. Handrails must provide at least one and one-half (1.5) inches between the inner side of the rail and support wall
3. Handrails must be located between thirty-four (34) inches to thirty-eight (38) inches above the tread of the step or ramp surfaces.

J. Steps, ramps and platforms and landing(s) associated with them must be:

1. Designed for at least one hundred (100) pounds per square foot.
2. Have a slip-resistant surface.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.7 Transportation of Individuals Receiving Services

Providers/programs providing transportation in program vehicles to individuals receiving services must meet the following criteria:

A. All vehicles and drivers must comply with the applicable laws of Mississippi regarding motor vehicle operation, ~~inspection~~, licensure, maintenance, and be kept in good repair.

B. When transporting individuals receiving services, the following staff to individual ratios applies only for the stated populations below:

   3. When transporting children age zero to six (0-6) years, the staff ratio in addition to the driver must be one (1) staff to five (5) children and one (1) staff to three (3) children when more than three (3) are infants or toddlers (0-24 months).
   4. When transporting individuals with intellectual/developmental disabilities, there must be one (1) staff (which can be the driver) for every six (6) individuals. For seven (7) to twelve (12) individuals, there must be one staff in addition to the driver. If an individual utilizes a wheelchair an additional staff member is required.

C. The vehicle must have a securely mounted/fixed fire extinguisher with proof of annual inspection, flares or reflectors, a flashlight, and first aid kit which contains the following: gloves, adhesive bandages, gauze, first aid tape, sterile pads, antiseptic wipes, and a first aid booklet. All items must be current.

D. All vehicles must have liability insurance unless otherwise authorized by state law. Proof of insurance must be kept in the vehicle.

E. All vehicles must be equipped with a secure, operable seat belt for each passenger transported. Children must be seated in approved safety seats with proper restraint in accordance with state law.

F. Providers that provide transportation must have policies and procedures in place to protect the safety and well-being of individuals being transported. Policies and procedures must address, at a minimum:

   7. Accessibility based on the individuals' needs and reasonable requests
   8. Accounting of individuals entering and exiting the provider/program vehicle. This must be made available for review.
   9. Availability of communication devices (i.e., cell phones, 2-way radios, etc.)
   10. Availability of a vehicle maintenance log for all vehicles used to provide transportation
   11. Course of action when staff is unable to leave individuals at home or an alternate site as specified by family/legal representative that ensures the safety of individuals at all times.
   12. Availability of additional staff to assist with transportation if the needs of the individuals being transported warrant additional staff assistance.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.8 Medication Control and First Aid Kits

C. Providers must have written policies and procedures and documentation of their implementation pertaining to medication control which assures that:

1. The administration of all prescription drugs and/or ~~hazardous~~ other medical procedures must be directed and supervised by a licensed physician or a licensed nurse in accordance with the Mississippi Nursing Practice Law and Rules and Regulations.
2. All medications must be clearly labeled. Labeling of prescription medications must also include the name of the individual for whom it was prescribed.
5. Medication prescribed for a specific individual must be discarded when no longer used by said individual and according to a written procedure to do so.
6. Adequate space is provided for storage of drugs that is well lighted and kept securely locked. (Exception: Supported Living Shared Supported, and Host Home)
7. Medication stored in a refrigerator which contains items other than drugs will be kept in a separate locked compartment or container with proper labeling. (Exception: Supported Living, Shared Supported and Host Home)
8. ~~7.~~ Drugs for external and internal use will be stored in separate cabinets or on separate shelves which are plainly labeled according to such use. (Exception: Supported Living, Shared Supported and Host Home)
13. ~~8.~~ Prescription drugs will be stored in a separate cabinet or compartment utilized only for that purpose. Prescription drugs must not be stored with nonprescription drugs. All drugs must be stored in a location utilized only for storage of prescription and nonprescription drugs. (Exception: Supported Living, Shared Supported and Host Home)
14. ~~9.~~ Transporting and delivery of medications follows any rules, regulations, guidelines, and statutes set forth by governing bodies authorized to do such.
15. ~~10.~~ Practices for the self-administration of medication by individuals served in a program are developed with consultation of the medical staff of the provider or the individual's treating medical provider(s).

D. Each ~~facility/program~~ site must have a first aid kit. The kit must contain gloves, adhesive bandages, gauze, first aid tape, sterile pads, antiseptic wipes, and a first aid booklet. For buildings housing more than one program, a single first aid kit may be used by all programs, if readily/easily accessible for all individuals in the building. All items must be current.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 13.9 Disaster Preparedness and Response

H. An Emergency/ Disaster Response Plan must be developed and maintained for each site, information may be similar to other locations, but specific site information is required. A

Continuity of Operations Plan (COOP) must be developed for each agency and a copy maintained at each site location.

I. Providers must develop and maintain an emergency/disaster response plan for each facility/program that is specific to each certified location/site, approved by the governing body, for responding to natural disasters, manmade disasters (fires, bomb threats, utility failures and other threatening situations, such as workplace violence). The plan should identify which events are most likely to affect the facility/program. This plan must address at a minimum:

16. Lines of authority and Incident Command;
17. Identification of a Disaster Coordinator;
18. Notification and plan activation;
19. Coordination of planning and response activities with local and state emergency management authorities;
20. Assurances that staff will be available to respond during an emergency/disaster;
21. Communication with individuals receiving services, staff, governing authorities, and accrediting and/or licensing entities;
22. Accounting for all persons involved (staff and individuals receiving services);
23. Conditions for evacuation;
24. Procedures for evacuation;
25. Conditions for agency closure;
26. Procedures for agency closure;
27. Schedules of drills for the plan;
28. The location of all fire extinguishing equipment, carbon monoxide detectors (if gas or any other means of carbon monoxide emission is used in facility) and alarms/smoke detectors;
29. The identified or established method of annual fire equipment inspection; and,
30. Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.

J. Providers must develop and maintain a Continuity of Operations Plan, approved by the governing body, for responding to natural disasters, manmade disasters, fires, bomb threats, utility failures and other threatening situations, such as workplace violence. This plan must address at a minimum:

1. Identification of provider's essential functions in the event of emergency/ disaster;
2. Identification of necessary staffing to carry out essential functions;
3. Delegations of authority;
4. Alternate work sites in the event of location/site closure;
5. Identification of vital records and their locations; and,
6. Identification of systems to maintain security of and access to vital records.

K. Copies of the Emergency/Disaster Response Plans and the Continuity of Operations Plan must be maintained on-site for each facility/program and at the agency's administrative offices.

L. All ~~locations/sites~~ agencies must document implementation of the written plans for emergency/disaster response that are specific to that location/site and continuity of operations. This documentation of implementation must include, but is not limited to the following: (Exception: Host Homes, Shared Supported and Supported Living.)

1. Quarterly fire drills for day programs
2. Monthly fire drills for supervised living and/or residential treatment programs, conducted on a rotating schedule within the following time frames:
   (a) 7 a.m. to 3 p.m.
   (b) 3 p.m. to 11 p.m.
   (c) 11 p.m. to 7 a.m.
3. Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.
4. Annual drill of Continuity of Operations Plan for the agency with documentation maintained at the main office.

M. ~~E.~~ All community living, residential treatment programs, and/or Crisis Stabilization Units must maintain current emergency/disaster preparedness ~~supplies~~ kits to support individuals receiving services and staff for a minimum of seventy-two (72) hours post event. At a minimum, these supplies must be kept in one place and include the following:

1. Non-perishable foods;
2. Manual can opener;
3. Water;
4. Flashlights and batteries;
5. Plastic sheeting and duct tape;
6. Battery powered radio;
7. Personal hygiene items.

N. ~~F.~~ All community living, residential treatment programs, and/or Crisis Stabilization Units must have policies and procedures that can be implemented in the event of an emergency that ensure medication, prescription and nonprescription, based on the needs of the individuals in the program and guidance of appropriate medical staff is available for up to seventy-two (72) hours post-event.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 14: Rights of Individuals Receiving Services

Rule 14.1 Rights of Individuals Receiving Services

B. There must be written and implemented policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal representative(s) is informed of their rights while served by the program, at intake and at least annually thereafter if he/she continues to receive services. These rights are applicable to all individuals receiving services except for individuals that have been civilly committed or individuals who are confined to a correctional facility. The individual receiving services and/or parent/legal representative must also be given a written copy of these rights, which at a minimum, must include:

1. The ~~options~~ services within the program and ~~of~~ other services available regardless of cultural barriers and limited English proficiency;

2. The right to access services that support an individual to live, work and participate in the community to the fullest extent of the individual's capability;

3. The right to services and choices, along with program rules and regulations, that support recovery/resiliency and person-centered services and supports;

4. The right to be referred to other providers services and supports in the event the provider is unequipped or unable to serve the individual;

5. The right to refuse treatment/services;

6. The right to ethical treatment including but not limited to the following:

   (a) The right not to be subjected to corporal punishment
   (b) The right to be free from all forms of abuse or harassment
   (c) The right to be free from restraints of any form that are not medically necessary or that are used as a means of coercion, discipline, convenience or retaliation by staff
   (d) The right to considerate, respectful treatment from all employees and volunteers of the provider program.

7. The right to voice opinions, recommendations, and to file a written grievance which will result in program review and response without retribution;

8. The right to personal privacy, including privacy with respect to ~~facility~~ visitors in day programs and community living programs as much as physically possible;

9. The right to not be discriminated against based on HIV or AIDS status.

10. The right to considerate, respectful treatment from all employees of the provider program;

11. The right to have reasonable access to the clergy and advocates and access to legal counsel at all times;

12. The right of the individual being served to review his/her records, except as restricted by law;

13. The right to participate in and receive a copy of the individual plan (as defined in Rule 17.1) including, but not limited to, the following:

    (a) The right to make informed decisions regarding his/her care and services, including being informed of his/her health status (when applicable), being involved in care/service planning and treatment and being able to request or refuse treatment/service(s). This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.
    (b) The right to access information contained in his/her case record within a reasonable time frame. (A reasonable time frame is within five (5) days; if it takes longer, the reason for the delay must be communicated). The provider must not frustrate the legitimate efforts of individuals being served to gain access to their own case records and must actively seek to meet these requests as quickly as its record keeping system permits. MCA 41-21-102 (7) does allow for restriction to access to records in certain circumstances where it is medically contraindicated.
    (c) The right to be informed of any hazardous side effects of medication prescribed by staff medical personnel.

14. The ability to retain all Constitutional rights, except as restricted by due process and resulting court order;

15. The right to have a family member or representative of his/her choice notified promptly of his/her admission to a hospital;

16. The right to receive care in a safe setting;

17. The right to involve or not involve family and/or others is recognized and respected; and,

18. The right to engage in planning, development, delivery and the evaluation of the services an individual is receiving.

19. The right to have visitors of his/her choosing at any time, to the greatest extent possible. Visitation rights cannot be withheld as punishment or in any other manner that unreasonably infringes on the individual's stated rights;

20. The right to daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated. If restrictions to communication are put in place, the individual has the right to following:

    (a) Any restrictions on private telephone use must be reviewed daily
    (b) All actions regarding restrictions on outside communication must be documented in the individual's record
    (c) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.2 Staff Roles in Protecting Rights of Individuals Receiving Services

H. The provider must define each staff member's responsibility in maintaining an individual's rights, as well as the ability to explain these rights to the individuals receiving services or their family members/legal representatives.

I. The provider's policies and procedures must be written in such a way that staff member's roles in maintaining or explaining these rights are clearly defined.

J. The policies and procedures must also clearly explain how the provider will train staff members to develop and retain the skills needed to uphold this role. This includes specific training regarding each right and how to explain it in a manner that is understandable to the individual and/or family member/legal representative. Training must focus on the population being served, but can include other related areas for broadened understanding.

K. An individual receiving services cannot be required to do work which would otherwise require payment to other program staff or contractual staff. For work done, wages must be in accordance with local, state, and federal requirements (such as the provision of Peer Support Services by a Certified Peer Support Specialist) or the program must have a policy that the individuals do not work for the program.

L. A record of any individuals for whom the provider is the legal representative or a representative payee must be on file with supporting documentation.

M. For programs serving as conservator or representative payee, the following action must be taken for each individual:

    1. A record of sums of money received for/from each individual and all expenditures of such money must be kept up to date and available for inspection by DMH staff
    2. The individual and/or his/her ~~lawful agent~~ legal representative must be furnished ~~a~~ receipts, signed by the lawful agent(s) of the program, for all sums of money received and expended at least quarterly.

N. When planning and implementing services that offer individuals the opportunity for community ~~inclusion~~ participation, providers shall recognize that:

1. Individuals retain the right to assume informed risk. The assumption of risk is required to consider and balance the individual's ability to assume responsibility for that risk and a reasonable assurance of health and safety;
2. Individuals make choices during the course of the day about ~~his or her~~ their everyday life, including daily routines and schedules; and,
3. Individuals have the opportunity to develop self-advocacy skills including but not limited to registering to vote.
4. Individuals must be afforded the same access to the community as people who do not have a mental illness, intellectual/ developmental disability or substance use disorder.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.3 Ethical Conduct

C. In addition to complying with ethical standards set forth by any relevant licensing or professional organizations, the governing authority and all staff members and volunteers (regardless of whether they hold a professional license) must adhere to the highest ethical and moral conduct in their interactions with the individuals and family members they serve, as well as in their use of program funds and grants.

D. Breaches of ethical or moral conduct toward individuals, their families, or other vulnerable persons, include but are not limited to, the following situations from which a provider is prohibited from engaging in:

1. Borrowing money or property
2. Accepting gifts of monetary value
3. Sexual (or other inappropriate) contact
4. Entering into business transactions or arrangements. An exception can be made by the Executive Director of the certified provider. The Executive Director of the certified provider is responsible for ensuring that there are no ethical concerns associated with the hiring and supervision practices.
5. Physical, mental or emotional abuse
6. Theft, embezzlement, fraud, or other actions involving deception or deceit, or the commission of acts constituting a violation of laws regarding vulnerable adults, violent crimes or moral turpitude, whether or not the employee or volunteer is criminally prosecuted and whether or not directed at individuals or the individuals' families
7. Exploitation
8. Failure to maintain proper professional and emotional boundaries
9. Aiding, encouraging or inciting the performance of illegal or immoral acts
10. Making reasonable treatment-related needs of the individual secondary or subservient to the needs of the employee or volunteer

11. Failure to report knowledge of unethical or immoral conduct or giving false statements during inquiries to such conduct
12. Action or inaction, which indicates a clear failure to act in an ethical, moral, legal, and professional manner
13. Breach of and/or misuse of confidential information.
14. Retaliation of any type towards an employee who reports, in good faith, a grievance, serious incident, concern with possible noncompliance with DMH Standards or DMH professional credentialing requirements.
15. Failure to report suspected or confirmed abuse or neglect of an individual receiving services in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.4 ~~Cultural Competency/~~Limited English Proficiency Services and Cultural Competency

C. Language assistance services, including bilingual staff and interpreter services, must be offered at no cost to individuals with limited English proficiency. These services must be offered at all points of contact with the individual while he/she is receiving services. A detailed description of when and how these services will be provided must be clearly explained in the provider's policies and procedures.

B. ~~Language assistance services must be offered in a timely manner during all hours of operation~~.

~~C. Verbal offers and written notices informing individuals receiving services of their rights to receive language assistance services must be provided to individuals in their preferred language~~.

D. ~~Service providers must assure the competence of the language assistance provided.~~

E. ~~Family and/or friends of the individual receiving services should only be utilized to provide interpreter services when requested by the individual receiving services.~~

~~F. Service providers must make available easily understood consumer related materials and post signage in the language of groups commonly represented in the service area.~~

D. All providers must develop and implement policies and procedures that address Culturally and Linguistically Appropriately Services (CLAS) federal guidelines developed by the Office of Minority Health (OMH), which is part of the US Department of Health and Human Services in order to improve access to care for Limited-English proficient individuals through the elimination of language and cultural barriers. All policies and procedures must include:

5. The process for offering language assistance to individuals who have limited English proficiency and/or other communication needs, at no cost to them, to facilitate timely access to all services.
6. How the agency informs individuals of the availability of language assistance services clearly and in their preferred language, verbally and in writing.
7. Ensure the competence of individuals providing language assistance, recognizing that the use of untrained individuals and/or minors as interpreters should be avoided.
8. Provide easy-to-understand print and multimedia materials and signage in the languages commonly used by the population in the service area.

E. Cultural competence describes the ability of an agency to provide services to individuals with diverse values, beliefs, and behaviors, including tailoring service delivery to meet the individual's social, cultural and linguistic needs. Policies and procedure manual must reflect the agency's efforts to integrate values, attitudes and beliefs of the individuals served into the services provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.5 Local Grievance Policies and Procedures

C. There must be written policies and procedures for implementation of a process through which individuals' grievances can be reported and addressed at the local program/center level. These policies and procedures, minimally, must ensure the following:

1. That individuals receiving services from the provider have access to a fair and impartial process for reporting and resolving grievances;
2. That individuals are informed and provided a copy of the local procedure for filing a grievance with the provider and of the procedure and timelines for resolution of grievances;
3. That individuals receiving services and/or parent(s)/legal representative(s) are informed of the procedures for reporting/filing a grievance with the DMH, including the availability of the toll free telephone number;
4. That individuals receiving services and/or parent(s)legal representative(s) are informed of the procedures for reporting suspicions of abuse or neglect in accordance with state reporting laws to include but not limited to the Vulnerable Persons Act and Child Abuse or Neglect Reporting requirements.
5. ~~4.~~ That the program will post in a prominent public area the Office of Consumer Support (OCS) informational poster containing procedures for filing a grievance with DMH. The information provided by OCS must be posted at each site/service location.

D. The policies and procedures for resolution of grievances at the provider level, minimally, must include:

1. Definition of grievances: a written or verbal statement made by an individual receiving services alleging a violation of rights or policy;
2. Statement that grievances can be expressed without retribution;
3. The opportunity to appeal to the executive officer of the provider agency, as well as the governing board of the provider agency;
4. Timelines for resolution of grievances; and,
5. The toll-free number for filing a grievance with the DMH Office of Consumer Support.

C. There must be written documentation in the record that each individual and/or parent guardian is informed of and given a copy of the procedures for reporting/filing a grievance described above, at intake and annually thereafter if he/she continues to receive services from the provider.

D. The policies and procedures must also include a statement that the DMH Certified Provider will comply with timelines issued by DMH Office of Consumer Support in resolving grievances initially filed with the DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.6 Use of Restraints

B. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support or if authorized as part of a behavior support plan for individuals with IDD. A mechanical restraint is the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

B. Providers are prohibited from the use of seclusion except for certified Crisis Stabilization Services. (See Rule ~~19.3~~ 19.5.P–R) Seclusion means a behavior control technique involving locked isolation. Such term does not include a time-out.

C. Providers are prohibited from the use of chemical restraints. A chemical restraint is a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.

J. Providers must ensure that all direct service staff who ~~may~~ utilize physical restraint/escort has successfully completed training and hold nationally recognized certification or DMH-approved training for managing aggressive or risk-to-self behavior (which includes verbal and physical de-escalation).

K. Providers must maintain a listing of all supervisory or senior staff members who have successfully completed required training and demonstrate competency in utilization of physical restraint.

L. Providers utilizing physical restraint(s)/escort must establish, implement, and comply with written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum:

1. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use. The definitions must state, at a minimum:
   (a) A physical restraint is personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.
   (b) A physical escort is the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.
2. Requirements that ~~in emergency situations physical restraint(s)/escort may be utilized only when it is determined crucial to protect the individual from injuring himself/herself or others.~~ physical restraint(s)/escort may be utilized only in emergency situations to protect the individual from injuring himself/herself or others. An emergency is defined as a situation where the individual's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, or staff.

G. Requirements that physical restraints/escorts are used as specified in the Behavior Management Plan, ID/DD Waiver Behavior Support Plan/Crisis Intervention Plan only when all other less restrictive alternatives have been determined to be ineffective to protect the individual or others from harm. The utilization of other less restrictive alternatives must be documented in the individual's case record.

H. Providers must establish and implement policies and procedures that physical restraint is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of physical restraint. Additionally, individuals must not be restrained for more than ~~sixty (60)~~ fifteen (15) minutes at any one time. They must be released after those ~~sixty (60)~~ fifteen (15) minutes. A face-to-face assessment must take place ~~at least every twenty (20) minutes~~ while the individual is being restrained.

I. Providers must establish and implement policies and procedures specifying that physical restraint(s)/escort must be in accordance with a written modification to the comprehensive plan of the individual being served as well as all of the following:

1. Requirement(s) that physical restraint(s)/escort must be implemented in the least restrictive manner possible;
2. Requirement(s) that physical restraint(s)/escort must be in accordance with safe, ~~appropriate~~ approved restraining techniques based on techniques taught as part of certification in a behavior management technique; and;

3. Requirement(s) that physical restraint(s)/escort must be ended at the earliest possible time (i.e., when the individual's behavior has de-escalated and that individual is no longer in danger of harming him/herself or others);
4. Requirement(s) that physical restraint(s)/escort must not be used as a form of punishment, coercion or staff convenience;
5. Requirement(s) that supine and prone restraints are prohibited as part of an individual's Behavior~~al Management Program~~ Support Plan; and
6. Requirement(s) that all physical restraint(s)/escort can only be implemented by someone holding certification (see Rule 12.5.B.)

J. Requirements that physical restraint(s)/escort are being used in accordance with a Behavior ~~Management~~ Support Plan, ID/DD Waiver Behavior Support Plan/ Crisis Intervention Plan by order of a physician or other licensed independent practitioner as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider and documented in the case record.

K. Providers must establish and implement written policies and procedures regarding the use of physical restraint(s)/escort with implementation (as applicable) documented in the Behavior ~~Management~~ Support Plan, ID/DD Waiver Behavior Support Plan/ Crisis Intervention Plan and in each individual case record:

1. Orders for the use of physical restraint(s)/escort must never be written as a standing order or on an as needed basis (that is, PRN).
2. A Behavior ~~Management~~ Support Plan must be developed by the individual's treatment team when these techniques are implemented more than three (3) times within a thirty (30) day period with the same individual. The Behavior ~~Management~~ Support Plan or ID/DD Waiver Behavior Support/Crisis Intervention Plan must address the behaviors warranting the continued utilization of physical restraint(s)/escort procedure in emergency situations. The Behavior ~~Management~~ Support Plan or ID/DD Waiver Behavior Support/Crisis Intervention Plan must be developed with the signature of the program's director who meets the qualification in Rule 11.3.
~~3. In physical restraint situations, the treating physician must be consulted within twenty-four (24) hours and this consultation must be documented in the individual's case record.~~
3. ~~4.~~ A supervisory or senior staff person with training and demonstrated competency in physical restraint(s) who is competent to conduct a face-to-face assessment will conduct such an assessment of the individual's mental and physical well-being as soon as possible but not later than within one (1) hour of initiation of the intervention. Procedures must also ensure that the supervisory or senior staff person trained monitors the situation for the duration of the intervention.
4. ~~5.~~ Requirements that staff records an account of the use of a physical restraint(s)/escort in a behavior management log that is maintained in the individual's case record by the end of the working day.
5. If you are unable to manage the individuals behavior, policies must be developed to address additional options staff are to take (ie. call mobile crisis team, 911, etc.).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.7 Time-Out

E. Programs utilizing time-out must have written policies and procedures that govern the use of time-out and documentation of implementation of such procedures in case records of individuals receiving services. The use of time-out is prohibited for individuals with intellectual and development disabilities. The policy/procedures must include, at a minimum, the following provisions:

   2. Clear definition(s) of time-out and the appropriate conditions and documentation associated with its use:
      (a) A time-out is a behavior management technique which removes an individual from social reinforcement into a non-locked room, for the purpose of calming. The time-out procedure must be part of an approved treatment program. Time-out is not seclusion.
      (b) Quiet time is a behavior management technique that is part of an approved treatment program and may involve the separation of the individual from the group, for the purpose of calming. Quiet time is not time-out.
   2. Requirement(s) ensuring that the use of time-out procedures is justified as documented and approved in an individual plan.
   3. Requirement(s) ensuring that time-out is used only after less restrictive procedures have been implemented and determined to be ineffective. The utilization of other less restrictive alternatives must be documented in the individual case record.
   4. Requirement(s) that a locked door must not be component of timeout.

F. Programs utilizing time-out must have written and implemented policies and procedures that time-out is utilized only for the time necessary to address and de-escalate the behavior requiring such intervention and in accordance with the approved individualized plan for use of time-out. Placement of an individual in a time-out room cannot exceed one (1) hour. ID/DD Waiver Services of any type are prohibited from the use of time-out.

G. There must be written and implemented policies and procedures requiring that a Behavior Management Plan be developed by the individual's treatment/support team, including participation of the individual as appropriate, to address the behavior(s) warranting the utilization of the time-out procedure and adhere to the following:

   1. The Behavior Management Plan must be developed in accordance with the individual's plan and have signature approval by the program's director who meets the qualification in Rule 11.3.
   2. The Behavior Management Plan must not include the use of time-out as a form of punishment, coercion or for staff convenience.

H. The utilization of time-out must be documented in a behavior log completed/maintained in the individual's case record.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 14.9 Search and Seizure

C. Agencies must develop policies and procedures regarding the search of the individual's room, person and/or possessions (Exception: Unannounced searches may not be conducted in Supported Living, Shared Supported Living and Host Home settings unless there is reason to believe that a crime has been committed), to include but not limited to;

1. Circumstances in which a search may occur;
2. Staff designated to authorize searches;
3. Documentation of searches; and
4. Consequences of discovery of prohibited items.

D. Policy regarding screening for prohibited/illegal substances (Exception: Staff may not screen for prohibited/illegal substances in Supported Living, Shared Supported Living and Host Home settings unless there is reason to believe that a crime has been committed; in which case, law enforcement should be contacted immediately), to include but not limited to:

1. Circumstances in which screens may occur;
2. Staff designated to authorize screening;
3. Documentation of screening;
4. Consequences of positive screening of prohibited substances;
5. Consequences of refusing to submit to a screening; and
6. Process for individuals to confidentially report the use of prohibited substances prior to being screened.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

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Part 2: Chapter 15: Serious Incidents

Rule 15.1 Serious Incidents to Report to DMH Within Twenty-Four (24) Hours of Incident

C. The following are examples (not an exhaustive list) of types of serious incidents that must be reported to the DMH, ~~Bureau of Quality Management, Operations & Standards~~ Office of Incident Management and other appropriate authorities within twenty-four (24) hours or the next working day, as specified below:

1. Suicide attempts on provider property at a provider-sponsored event, or by an individual being served through a community living program;
2. ~~Unexplained absence from all community living programs, Crisis Stabilization Units, Primary Residential Treatment or Transitional Residential Treatment Programs of twelve (12) hour any duration;~~
2. ~~3.~~ Unexplained or unanticipated absence of an individual receiving services of any length of time from any DMH certified ~~day~~ program of any type ~~(i.e., wandering away from the premises);~~
3. ~~4.~~ Incidents involving injury of an individual receiving services while on provider property, at a provider-sponsored event, or being transported by a DMH Certified Provider;
4. ~~5.~~ Emergency hospitalization or emergency room treatment of an individual ~~while in the program~~ receiving services;
5. ~~6.~~ Accidents which require hospitalization that may be related to abuse or neglect, or in which the cause is unknown or unusual;
6. ~~7.~~ Disasters, such as fires, floods, tornadoes, hurricanes, blizzards, etc;
7. ~~8.~~ Any type of mandatory evacuation by local authorities that affects the program/facility or site; and,
8. ~~9.~~ Use of seclusion or restraint that was not part of an individual's treatment Behavior Management Plan, or ID/DD Waiver Behavior Support/Crisis Intervention Plan that was planned but not implemented properly, or resulted in discomfort or injury for the individual.

D. Serious incidents must be reported in writing to DMH, ~~Bureau of Quality Management, Operations & Standards~~ Office of Incident Management within twenty-four (24) hours of the incident. Additional information may be requested based on the circumstances. The written report must address initial information known about the incident to include, but not limited to:

11. Name of Provider
12. ~~1.~~ Date;
13. ~~2.~~ Time;
14. ~~3.~~ Physical location;
15. ~~4.~~ Who was involved;
16. ~~5.~~ What led to the incident;
17. ~~6.~~ A description of the incident;
18. ~~7.~~ Consequences of incident;

19. ~~8.~~ Witnesses; and,
20. ~~9.~~ Notifications.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 15.2 Serious Incidents to Report to DMH Within Eight (8) Hours of Discovery or Notification of Incident

A. Serious incidents that must be reported to the DMH Office of Incident Management within eight (8) hours of discovery or notification of the incident include:

1. Death of an individual on provider property, participating in a provider-sponsored event, being served through a certified community living program, Crisis Stabilization Unit, Primary Residential Treatment , Transitional Residential Treatment, and/or being served through the ID/DD Waiver,
2. Unexplained absences from any of the previously mentioned programs or Alzheimer's Day Services programs.
3. Suspicions of abuse or neglect of an individual receiving services while on provider property, at a provider-sponsored event, or being transported by a DMH Certified Provider.

B. The above listed incidents must be reported verbally to the Office of ~~Consumer Support~~ Incident Management within eight (8) hours to be followed by the written Serious Incident Report within twenty-four (24) hours as outlined in Rule 15.1.B.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 15.3 Policies and Procedures for Serious Incidents

The provider must have written and implemented policies and procedures in place regarding serious incidents that include:

K. What constitutes a serious incident;

L. Prevention of serious incidents;

M. Remedial actions;

N. Reporting of serious incidents;

O. Documentation of serious incidents;

P. Training and documentation that staff have received, and acknowledged, information on required reporting of abuse, neglect and/or exploitation of a vulnerable person;

Q. Maintenance of documentation related to serious incidents;

R. Assurance of cooperation with DMH for follow up to serious incidents;

S. Analysis of all serious incidents; and,

T. Staff responsible for analysis of serious incidents.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 15.4 Written Analyses of All Serious Incidents

E. The governing authority or a committee designated by the governing authority (which can include the Quality Management Committee required in Chapter 9) must review all serious incidents and conduct a written analysis of all serious incidents at least quarterly. Written analysis must be made available to DMH for review upon request.

F. If a committee is designated by the governing authority, that committee must include representatives of multiple disciplines and positions within the agency. For example, medical staff, administrative staff, human resources, clinical staff, etc.

G. The written analysis must address the following:

5. A determination of the cause of each incident;
6. Identification of any trends in serious incidents; and,
7. Remedial actions to be taken to prevent similar future events.

H. Remedial actions must be communicated to staff affected by the required actions.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 16: Service Organization

Rule 16.1 Determinations of Serious Emotional Disturbance (SED), Serious Mental Illness (SMI), and/or Intellectual/Developmental Disability (IDD)

D. All of the following information must be documented to support a determination of serious emotional disturbance:

1. Youth has at least one (1) of the eligible diagnosable mental disorders defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).
2. Youth with serious emotional disturbance are birth up to twenty-one (21) years.
3. The identified disorder must have resulted in functional impairment in basic living skills, instrumental living skills, or social skills, as indicated by an assessment instrument/approach approved by the DMH.

E. All of the following information must be documented to support a determination of serious mental illness:

1. An individual who meets the criteria for one of the eligible diagnostic categories defined in the most current version of the DSM.
2. Adults with serious mental illness are age eighteen (18) and over.
3. The identified disorder must have resulted in functional impairment in basic living skills, instrumental skills or social skills, as indicated by an assessment instrument/approach approved by the DMH.

F. All of the following must be documented to support admission to IDD programs:

1. ID/DD Waiver Services:
   (a) ~~(1)~~ The person meets the criteria for the level of care found in an intermediate care facility for ~~the intellectually disabled~~ individuals with intellectual disabilities (ICF/IID), as determined by the Diagnostic and Evaluation Team at one of the state's five (5) comprehensive IDD Regional Programs and
   (b) ~~(2)~~ Is eligible for Medicaid through one (1) of the categories specified in the federally approved ID/DD Waiver application; or
2. Other IDD Services: Meets the requirements for a Certificate of Developmental Disability as defined in the Developmental Disabilities Assistance Act.
3. IDD Community Support Program (CSP):
   (a) Meets the Needs-Based Criteria established in the 1915(i) Medicaid State Plan Amendment and
   (b) Meets the criteria for a Certificate of Developmental Disability.
   (c) Medicaid eligibility

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.2 Admissions to Services

C. The provider must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that:

1. Provide a phone number where contact can be made to arrange for an appointment;
2. Assure the person requesting services only has to make one call to arrange an appointment.

D. Written policies and procedures must address admission to services and must at a minimum:

1. ~~A.~~ Describe the process for admission and readmission to service(s).
2. ~~B.~~ Define the criteria for admission or readmission to service(s), including:
   (a) Description of the population to be served (age(s), eligibility criteria, any special populations, etc.)
   (b) Process for determination of appropriateness of services to address the needs of the individual seeking services
   (c) Number of residents to be served (providers of community living services only)
   (d) Expected results/outcomes
   (e) Methodology for evaluating expected results/outcomes.
3. ~~C.~~ Assure equal access to treatment and services and non-discrimination based on ability to pay, race, sex, age, creed, national origin, or disability for individuals who meet eligibility criteria.
   (a) For the ID/DD Waiver, a provider chosen by an individual cannot refuse to admit him/her solely on the basis of the his/her support needs, if an appropriate placement is available.
   (b) If an individual is denied admission, the provider must submit written justification for the denial to the individual's Support Coordinator to be maintained in the record;
   (c) Additional referrals may not be made by Support Coordination to providers who deny admission to someone who has chosen them for a period of one (1) month, or greater, depending on a provider's pattern of behavior of denying admission based on an individual's needed level of support.
4. ~~D.~~ Describe the process or requirements for intake/initial assessment, including the process for requesting appropriate consent to obtain relevant records from other providers.
5. ~~E.~~ Describe the procedure for individuals who are ordered to treatment by the court system.
6. ~~F.~~ Describe written materials provided to individuals upon admission, including materials that may be included in an orientation packet, etc.
7. ~~G.~~ Describe~~s~~ the process for informing individuals, youth (if age appropriate) and youth's parent(s)/legal representative(s) of their rights and responsibilities (including any applicable program rules) prior to or at the time of admission.

8. ~~H.~~ Describe the process to be followed when admission or readmission to service(s) offered by the provider is not appropriate for the individual, including referral to other agencies and follow-up, as appropriate. Such referral(s) and follow-up contacts must be documented.

21. ~~I.~~ Describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available by the provider.
22. ~~J.~~ Assure equal access to treatment and services for HIV-positive persons who are otherwise eligible
23. ~~K.~~ Describe procedures for providing a schedule to individuals and their families for each service and/or program that includes the hours of daily operation, number of days per year the service/program is available, and the scheduled dates of closure/unavailability and reasons.
24. ~~L. Individuals must acknowledge in writing any fees and the amount of the fee for which he/she will be responsible for payment.~~ Describe procedures for disbursing funds on behalf of individuals receiving services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.3 Discharge and Termination

A. Discharge and termination are two unique terms and actions.

B. Termination is the action utilized and documented to discontinue a service and/or program within a DMH Certified Provider agency.

C. Discharge is the action utilized and documented to signify that an individual is no longer receiving services through that particular DMH Certified Provider agency.

D. All providers must implement policies and procedures for discharge or termination from the service/program which must, at a minimum, address the following:

1. Reason(s) for discharge\termination.
2. Assessment of progress toward objectives contained in the individual plan
3. Discharge instructions given to the individual who received services or their authorized representative, parent(s)/legal representative(s), including referrals made
4. Any other information deemed appropriate to address the needs of the individual being discharged from the program.

E. In addition to Rule 16.3 D, all providers of community living services to children/youth in the custody of the MS Department of Human Services must adhere to the following regarding discharge:

4. The DHS social worker from the county of residence of the child/youth is provided the opportunity to be in involved in the discharge/placement plans if the child is in the custody of DHS.

5. Children and youth in the custody of the MS Department of Human Services are provided an opportunity for one pre-placement visit by their DHS Social Worker prior to discharge.
6. Documentation that an appointment has been scheduled with the CMHC responsible for services in the county where the child/youth will reside upon discharge.

F. Individuals living in community settings ~~where they have signed a lease and pay rent~~ cannot be discharged or terminated from the service in a manner that is not in full compliance with the terms of the signed lease/rental/ residential fee agreement. In addition, the community living service provider must ensure that alternative living arrangements are made that are appropriate for the individual. Those arrangements should be designed to mitigate the likelihood that the individual will be homeless as a result of being discharged or terminated from the community living program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.4 Program Postings

C. Program rules (if applicable) for any service and/or program must be posted in a location highly visible to the individuals served and/or made readily available to those individuals. (Exception: Supervised Living, Shared Supported Living, Supported Living and Host Homes.)

D. ~~For all programs (inclusive of locations where only outpatient services may be offered),~~ All Programs must post emergency ~~telephone~~ contact number(s) ~~must be posted~~ in a conspicuous location ~~near each telephone~~. Program postings in community living settings should not conflict with the efforts to provide a home-like environment for the individuals living in the setting. ~~Numbers must be included for:~~

~~1. Police~~
~~2. Fire~~
~~3. Poison Control Center~~
~~4. Ambulance/Emergency Medical Services (EMS)~~

C. For day programs of all types, community living programs of all types, and Crisis Stabilization Units, ~~Primary Residential Treatment Programs, and Transitional Residential Treatment Programs,~~ the following contact information should be kept securely at the program/service location and available to all staff:

1. Family member(s) or other contacts (if appropriate and consent is on file)
2. Community support specialist, Targeted Case Manager, Community Support Specialist, therapist, and/or Support Coordinator for individuals (if applicable).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.5 Service and Program Design

G. Activities must be designed to address objectives/outcomes in the individual plan directing treatment/support for the person. At a minimum, individual plan objectives/outcomes must reflect individual strengths, needs, preferences and behavioral ~~deficits/excesses~~ issues of individuals and/or families/guardians (as appropriate) served by the program or through the service as reflected by intake/assessments and/or progress notes.

H. Services and programs must be designed to provide a Person-Centered Recovery Oriented system of services with a framework of recovery supports that are self-directed, individualized, culturally responsive, trauma informed, and that provide for community participation opportunities. Services should be measurable and individualized for each individual receiving services

I. ~~B.~~ Services and programs must be designed to promote and allow independent decision making by the individual and encourage independent living, without compromising the health and safety of the individuals being served. ~~as appropriate.~~

J. Providers must present information in a manner understandable to the individual so that he/she can make informed choices regarding service delivery and design, available providers and activities which comprise a meaningful day for him/her.

K. ~~C.~~ Programs must provide each individual with activities and experiences to develop the skills they need to support a successful transition to a more integrated setting, level of service, or level of care.

L. ~~D.~~ The services provided as specified in the individual plan must be based on the requirements of the individual rather than on the availability of services/staff.

~~E. Unless the behavioral issues put the individual or other individuals receiving services in jeopardy, prior to discharging someone from a service of any type due to challenging behavioral issues, the provider must have documentation of development and implementation of a Behavior Management Plan. All efforts to keep the individual enrolled in the day and/or community living program and/or service must be documented in the individual's record. In the event that it is determined that an individual's behavior and/or actions are putting other individuals receiving the service at risk for harm (whether physical or emotional), the development of the Behavior Management Plan is not required. The behavior and/or action that warranted discharge must be documented in the individual's record.~~

M. All efforts must be implemented to design a service environment that is safe and conducive to positive learning and life experiences. Persons served in the program whose behaviors are significantly disruptive to others in the same environment must be afforded the opportunity and assistance to change those behaviors through a systematic support

plan. Persons receiving services may not be discharged from a service or program due to disruptive behaviors unless they pose a risk for harm to other people receiving the service. Efforts to keep an individual enrolled in the service or program must be included in the plan and documented in the record.

N. Persons enrolled in ID/DD Waiver services must also collaborate with the Support Coordinator to determine a need for Behavior Support Services before a decision is finalized to discharge a person from the service.

O. ~~F.~~ If mental health services are provided in a school setting, the provider must maintain a current written interagency agreement(s) (including a confidentiality statement), signed by the Executive Officer of the mental health provider agency and the superintendent of the school district, that at a minimum:

1. Describes in detail the respective responsibility(ies) of each entity in the provision of mental health services provided in the local school and any support services necessary for the provision of that service (such as facilities, staffing, transportation, etc.).
2. Includes a written acknowledgment of the school district's receipt and understanding of standards applicable to the children's mental health services.

P. ~~G.~~ Within twenty-four (24) hours prior to the release or discharge of any civilly committed individual from community mental health services, other than a temporary pass or because of absence due to sickness or death in the patient's family, the program director or executive director must give or cause to be given notice of such release or discharge to one (1) member of the individual's immediate family, provided the individual, eighteen (18) years or older, has signed an appropriate consent to release such discharge information and has provided in writing a current address and telephone number, if applicable, to the director for such purpose.

Q. Services and plan development must reflect cultural considerations of the individual and be conducted by providing information in a plain language and in a manner that is accessible to the individuals and persons who have limited English proficiency.

R. For IDD Waiver Services, required staff must participate in the development of each person's plan of services and supports.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.6 Staffing

E. All services and programs must provide the level of staffing needed to ensure the health, safety, and welfare of the individuals served, and provide essential administrative and service functions.

B. Only a licensed health care professional can provide nursing care, medical services, or medication, in accordance with the criteria, standards, and practices set forth by their respective licensing entity.

C. ~~If contractual services are provided by a certified provider, or obtained by a certified provider, there must be a current written contractual agreement in place that addresses, at minimum, the following:~~

~~1. Roles and responsibilities of both parties identified in the agreement~~
~~2. Procedures for obtaining necessary informed consent, including consent for release and sharing of information~~
~~3. Assurances that DMH Operational Standards will be met by both parties identified in the agreement.~~
~~4. An annual review of the contractual agreement by both parties.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.7 Confidentiality

D. Personnel must maintain the confidentiality rights of individuals they serve at all times across situations and locations, such as in waiting areas to which the public has access, while speaking on the telephone or, in conversing with colleagues.

E. The provider must have written policies and procedures and related documentation pertaining to the compilation, storage, and dissemination of individual case records that assure an individual's right to privacy and maintains the confidentiality of individuals' records and information.

F. Compilation, storage and dissemination of individual case records, including related documentation, must be in accordance with these policies and procedures, which at a minimum must include:

1. Designated person(s) to distribute records to staff;
2. Specific procedures to assure that records are secure in all locations;
3. Procedures to limit access to records to only those who have been determined to have specific need for the record, including written documentation listing those persons;
8. Procedures for release of information that are in accordance with all applicable state and federal laws. Generally, this means case records and information shall not be released except upon prior written authorization of the individual receiving services or his/her legally authorized representative; upon order of a court of competent jurisdiction; upon request by medical personnel in a medical emergency or when necessary for the continued treatment or continued benefits of the individual. These procedures at a minimum must:

(d) Describe the process for releasing information about individuals receiving services only upon written consent, including the identification of the staff responsible for processing inquiries or requests for information regarding individuals receiving services.
(e) Describe the process for releasing information about an individual receiving without prior written consent, that is, in cases of a medical emergency or upon receipt of a court order.
(f) Provide that written consent to release information is not combined with any other consents or releases by the individual receiving services.

5. Procedures prohibiting the disclosure that a person answering to a particular description, name, or other identification has or has not been attending the program without prior written consent of the person specifically authorizing such disclosure;
6. Procedures prohibiting re-disclosure of information obtained by the program and released by the program without specific prior written consent of the person to whom it pertains;
7. Procedures requiring written consent of the individual receiving services or their guardian, when appropriate, prior to disclosing identifying information to third-party payer; and,
8. Procedures addressing the release of information regarding individuals receiving alcohol and other drug disorders services, in accordance with applicable federal regulations.

D. Records containing any information pertaining to individuals receiving services must be kept in a secure room or in a locked file cabinet or other similar container when not in use;

E. All <u>paper</u> case records must be marked "confidential" or bear a similar cautionary statement; <u>all electronic health records or digital filing must be privacy protected and contain a statement of confidentiality or similar cautionary statement;</u> and

F. No program shall release records of individuals receiving services for review to a state or federal reviewer other than DMH staff without a written statement indicating:

1. The purpose of the review;
2. Staff to conduct the review;
3. That reviewer(s) are bound by applicable regulations regarding confidentiality and all others that apply; and,
4. Reviewer(s) signature(s) and the date signed.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 16.8 Case Record Management</u>

F. A single case record must be maintained for each individual receiving services (exception: A/D Prevention Services<u>, Consultation and Education Services and Family</u>

Support and Education Services) from the provider agency. ~~Programs~~ In lieu of access to case records staff must ~~may~~ utilize an on-site working record that contains ~~copies of~~ information from the case record that is utilized ~~in order~~ to provide services at that location (e.g., individual plans, emergency contact information, ~~activity plans~~, and medication profile).

G. The provider must maintain an indexing or referencing system that allows for locating particular individual case records whenever they are removed from the central file area.

H. Records of individuals served must be readily accessible to authorized staff and there must be written procedures assuring accessibility to records by emergency staff after hours.

I. All entries in individuals' records must be in a permanent form (i.e. ink), accurate, legible, dated, signed, and include the credentials of staff making the entry. Corrections in the original information entered in the record(s) of individuals served by the program must be made by marking a single line through the changed information. Changes must be initialed and dated by the individual making the change. The correct information should be entered in the next available space. Correction fluid, erasing, or totally marking out original information is not permissible.

J. Late entries to the record should be avoided. However, late entries must also be documented. Late entries should be documented as soon as possible. Late entries should be identified as a "late entry". The date and time when the entry is actually being made must be included. Events described in the late entry must include the actual date and time (if available) that the event(s) occurred.

F. No information in an individual's record shall contain the whole name or other identifiable information of another individual receiving service.

G. For alcohol and other drug disorders services records, the case must be closed when no contacts are recorded for ninety (90) days.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 16.9 Assessment

G. Adults with a serious mental illness (SMI) and children and youth with serious emotional disturbance (SED) must be seen in person or by telemedicine and evaluated by a licensed physician, licensed psychologist, psychiatric/mental health nurse practitioner, physician assistant, licensed professional counselor (LPC) , licensed marriage and family therapist (LMFT), or Licensed Certified (clinical) Social Worker (LCSW) to certify that the services planned are medically/therapeutically necessary for the treatment of the individual. These professionals must see the individual in person or by telemedicine annually (or more often if medically indicated) to certify the same in the record.

H. Certification and recertification must be documented as part of the individual plan directing treatment/support.

I. For all individuals receiving mental health services and/or substance use disorders services, the initial biopsychosocial assessment and subsequent biopsychosocial assessments are the face-to-face securing of information from the individual receiving services and/or collateral contact, of the individual's family background, educational/vocational achievement, presenting problem(s), problem history, history of previous treatment, medical history, current medication(s), source of referral and other pertinent information in order to determine the nature of the individual's or family's problem(s), the factors contributing to the problem(s), and the most appropriate course of treatment for the individual and/or family.

J. The initial biopsychosocial assessment and subsequent biopsychosocial assessments must be completed by a DMH Credentialed Mental Health Therapist, DMH Credentialed IDD Therapist, DMH Credentialed Addictions Therapist or professionally licensed individual.

K. The following priority groups of individuals with serious mental illness, children/youth with serious emotional disturbance and individuals with an intellectual/developmental disability must receive an Initial Assessment within fourteen (14) days of the date that services are sought and/or the date the referral is made.

9. Individuals discharged from an inpatient psychiatric facility
10. Individuals discharged from an institution
11. Individuals discharged or transferred from Crisis Stabilization Services
12. Individuals referred from ~~Emergency/~~Crisis Response Services.

L. For individuals in need of Psychiatric/Physician Services, an appointment for those services must be made and documented during the initial biopsychosocial assessment.

G. For adults receiving Outpatient Mental Health Services, a DMH approved functional assessment must be conducted within thirty (30) days ~~after~~ of Initial Assessment and at least every twelve (12) months thereafter.

H. For children and youth receiving mental health services, a DMH approved functional assessment must be conducted within (30) days of Initial Assessment and at least every six (6) months thereafter.

1. If a child/youth has been evaluated by the school district or other approved examiner to determine the need/eligibility for special education services, the mental health service provider must document their request and/or receipt of such evaluation results, provided that appropriate written consent was obtained from the parents/legal representative to do so. Copies of the request(s) for the release of information and any special education evaluation results received must be maintained in the case record ~~as part of the Initial Assessment process and/or of the next occurring Individual Service Plan review.~~

N. For individuals with IDD who have been evaluated by one (1) of the five (5) Diagnostic and Evaluation Teams, ~~by a school district~~ or by another ~~approved~~ licensed examiner to determine the need for/eligibility for ICF/~~IDD~~ IID level of care, special education, the IDD Community Support Program and/or a Certificate of Developmental Disability, the evaluation(s) must be maintained in each individual's record as part of the initial assessment process.

O. For children ages thirty-six (36) months and younger, the assessment requirements for First Steps Early Intervention Programs are applicable.

P. For children participating in DMH Child Development Programs, a functional skills assessment must be administered annually. The provider may select the functional skills assessment with approval from the BIDD.

Q. For individuals receiving substance use disorders services, a DMH approved functional assessment must be conducted within timelines according to the service(s) received.

R. ~~L.~~ For Alcohol and Other Drug Disorders Services, all individuals receiving substance abuse treatment services must receive the TB and HIV/AIDS Risk Assessment at the time of the Intake/Initial Assessment except under the following circumstances:

1. For Transitional Residential Services - The Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying the assessment(s) was administered, with documentation of follow-up of results if applicable, in a primary treatment program completed within the last thirty (30) days.
2. For Recovery Support Services - The Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that both risk assessment(s) were administered with documentation of follow-up and results, if applicable, during substance abuse treatment program completed within the last thirty (30) days.

N. ~~M.~~ In addition to the Initial Assessment, a DUI Diagnostic Assessment for individuals in the DUI program for second and subsequent offenders must contain the following information:

(a) A motor vehicle report (or evidence of a written request) which is obtained by the service provider from the Department of Public Safety. This record must contain: Previous DUI's and Moving violations.
(b) The results and interpretations of the SASSI or other DMH approved diagnostic instrument. The approval must be obtained in writing.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 17: Individual Planning of Treatment, Services and Supports

Rule 17.1 Individual Plans

E. The individual plan is the overall plan that directs the treatment\support of the individual receiving services. The individual plan should be designed to increase or support independence and community ~~integration~~ participation. The individual plan may be referred to as the Treatment Plan, Plan of Services and Supports, Individual Service Plan, Wraparound Plan or Person-Centered Plan. The name of the plan is dependent upon the population being served and the process utilized to develop the plan.

F. The plan must be based on the strengths, challenges, desired outcomes, and activities to support outcomes of the individual receiving services and his/her family/legal representative (if applicable). Outcomes should be identified by the individual, family/legal representative (if applicable), and treatment/support team.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 17.2 Development of Individual Plans

D. Providers must utilize planning approaches that are considered to be best practices or evidence-based by their respective areas of focus (i.e. working with adults with SMI, children/youth with SED, individuals with co-occurring disorders, individuals with substance ~~abuse~~ use disorders and individuals with intellectual/developmental disabilities, the elderly, etc.). ~~Documentation that supports the identification of a best practice or evidence-based practice must be maintained by the provider and available for review.~~ Planning approaches must be documented and implemented through the development of policies and procedures specific to this process and the population being served.

E. Planning approaches must address the following, at a minimum:

5. The development of an individualized treatment/support team that includes the individual, service providers and other ~~providers of~~ supports (as appropriate) that may be identified and utilized by the individual or team members;
6. A focus on recovery/resiliency and/or person centeredness, depending on the population;
7. A focus on individual strengths and how to build upon strengths to achieve positive outcomes; and,
8. Proactive crisis planning, depending on the individual receiving services.

F. The Plan of Services and Supports for individuals with IDD

3. The individual will lead the person centered planning process where possible. The individual's representative/legal guardian should have a participatory role, as needed and as defined by the individual. The meeting:
   (a) Includes people chose by the individual.
   (b) Provides necessary information and support to ensure the individual directs the process to the maximum extent possible, and is enable to make informed choices and decisions.
   (c) Is timely and occurs at times and places convenient to the individual.
   (d) Reflects the cultural considerations of the individual and is conducted by providing information in plain language and in a manner that is accessible to the individuals with disabilities and person who are limited English proficient..
   (e) Includes strategies for resolving conflict or disagreement within the process .including clear conflict-of-interest guidelines for all planning participants.
   (f) Offers informed choices to the individual regarding the services and supports they received and from whom.
   (g) Includes a method for the individual to request updates to the plan as needed.
   (h) Records the alternative home and community based settings that were considered by the individual.

4. The Plan of Services and Supports must:
   (o) Reflect the services and supports that are important for the individual to meet the needs identified through an assessment of functional need as well as what is important to the him/her with regard to preferences for the delivery of such services and supports.
   (p) Reflect that the setting in which the individual resides is chosen by the individual. The setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access an individual not receiving ID/DD Waiver services.
   (q) Reflect the individual's strengths and preferences.
   (r) Reflect clinical and support needs as identified through the functional assessment.
   (s) Include individually identified outcomes for services.
   (t) Reflect the services and supports (paid and unpaid) that will assist the individual to achieved identified goals and the providers of those services and supports, including natural supports.
   (u) Reflect risk factors and measures in place to minimize them, including individuals back-up plans and strategies when needed.
   (v) Be understandable to the individual receiving services and supports, and the individuals important in supporting him/her. At a minimum, for the PSS to be understandable, it must be written in plain language and in a manner that is accessible to individuals with disabilities and persons who have limited English language proficiency.
   (w) Identify the individual and/or entity responsible for monitoring the PSS.

(x) Be finalized and agreed to, with the informed consent of the individual in writing, and be signed by all individuals and providers responsible for its implementation.

(y) Be distributed to the individual and others involved in implementing the PSS.

(z) Must prevent the provision of unnecessary or inappropriate services and supports.

(aa) Must Document that any modifications made to a person's ability to access the community or make choices about his/her daily life:

(1) Identify a specific and individualized assessed need.

(2) Have documentation of the positive behavior interventions and supports used prior to any modification of the person centeredness of the PSS.

(3) Have documentation that less intrusive methods have been tried and did not work.

(4) Include a clear description of the condition that is directly proportionate to the specific assessed need.

(5) Include regular collection and review of data to measure the ongoing effectives of the modification.

(6) Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

(7) Include the informed consent of the individual.

(8) Include an assurance that interventions and supports will cause no harm to the individual.

(bb) Reviewed and revised upon reassessment of the functional need, at least annually, when the individual circumstances or needs change significantly, or at the request of the individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 18: Targeted Case Management Services

Rule 18.1 Targeted Case Management Activities

A. Targeted Case Management Services ~~is~~ are defined as services that provide information/referral and resource coordination for individuals and/or his/her family, or other supports. ~~collaterals~~. Targeted Case Management Services are directed towards helping the ~~beneficiary~~ individual maintain his/her highest possible level of independence. ~~independent functioning~~. Case managers monitor the individual service plan and ensure team members complete tasks that are assigned to them, that follow up and follow through occur and help identify when the person's ~~treatment~~ team may need to review the service plan for updates if the established plan is not working.

B. Targeted case management may be provided face-to-face or via telephone. Targeted case management is not designed to be a mobile service, but there is no prohibition on services being provided in a location other than a community mental health center or IDD Regional Program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 18.2 Provision of Mental Health Targeted Case Management Services

A. Targeted Case Management must be included in the individual's plan.

B. The frequency of Targeted Case Management services will be determined by the complexity of the ~~case~~ situation and the need of the individual receiving services, but shall not occur less than once monthly.

G. The staff caseload for Mental Health Targeted Case Management Services must not exceed one hundred (100) individuals. ~~receiving the service~~. Caseload sizes must be based on the complexity of the needs of the ~~case~~ person and whether or not the staff member has additional responsibilities.

Rule 18.3 Provision of IDD Targeted Case Management Services

(1) IDD Targeted Case Management is provided by one (1) of the State's five (5) IDD Regional Programs.

(2) IDD Targeted Case Managers are responsible for the following:

1. Development of the Plan of Services and Supports
2. Coordination and monitoring of services to include the following:
   (f) Services are adequate, appropriate and meet the person's unique needs.

(g) Follow-up activities and contact that are necessary to ensure the PSS is effectively implemented and adequately addresses the person's support needs.

(h) Ensuring the changing needs of the individual are addressed on an ongoing basis.

(i) Providing resource information and referral to link individuals with medical, social, employment, educational or other providers and programs and services to meet the person's needs and achieve the outcomes identified in the PSS.

(j) Reassessing an individual at least annually for eligibility to ensure he/she continues to meet the needs-based criteria.

(3) Contacts include face-to-face or phone contacts with the person, family or legal representative(s), service providers or other entities. At least monthly, the IDD Targeted Case Manager must contact the individual receiving services and his/her legal representative to assess satisfaction with services and to address any changing needs. The IDD Targeted Case Manager must have face-to-face contact with the individual at every other month in the service setting. If a person is not receiving other services, the Targeted Case Manager must see him/her face-to-face at least quarterly.

(4) The caseload for IDD Targeted Case Management is thirty-five (35).

(5) IDD Targeted Case Managers must adhere to the requirements and guidelines in the IDD Targeted Case Management Manual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 19: Crisis Services

Rule 19.1 ~~Emergency~~/**Crisis Response Services**

E. Crisis Response is an intensive therapeutic service which allows for the assessment of and intervention in a mental health crisis. Crisis Response Services are provided to children and adults who are experiencing a significant emotional/behavioral crisis in which the individual's mental health and/or behavioral health needs exceed the individual's resources (in the opinion of the mental health professional assessing the situation.) ~~Time limited intensive intervention, available twenty-four (24) hours a day, seven (7) days a week. Crisis response services allow for the assessment of the crisis and ability to activate a mobile crisis team.~~ Trained Crisis Response staff provides crisis stabilization directed toward preventing hospitalization. ~~Children or adults requiring crisis services are those who are experiencing a significant emotional/behavioral crisis. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral health needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation.~~ Staff must be able to triage and make appropriate clinical decisions, including assessing the need for inpatient services or less restrictive alternatives. Crisis Response Services will deliver solution-focused and recovery-oriented behavioral health assessments and stabilization of crisis in the location where the individual is experiencing the crisis. Without Crisis Response intervention, the individual experiencing the crisis may be inappropriately and unnecessarily placed in a jail, holding facility, hospital or inpatient treatment facility. (Crisis Response Services do not include the Crisis Intervention/Crisis Support Services provided through the ID/DD Waiver.)

F. ~~Emergency~~/Crisis Response Services must be made available to the general public in every county/area served by providers certified by DMH to provide Crisis Response Services ~~Emergency/Crisis Response Services do not include the Crisis Intervention or Crisis Support Services provided through the ID/DD Waiver.~~

G. ~~Recipients of Emergency/Crisis Services do not have to be currently/previously enrolled in any of the services provided by the provider. Emergency/Crisis Services may be provided to an individual before he/she participates in the initial assessment that is part of the intake/admission process.~~

H. ~~The provider must ensure that a mental health representative is available to speak with an individual in crisis and/or family members/legal representatives of the individual twenty-four (24) hours a day, seven (7) days a week, inclusive of individuals who may be a "walk-in" at any program site. An accessible toll free number must be made available for this purpose. Emergency/Crisis service availability must be publicized, including a listing in the telephone directories for each county served by the provider and the homepage of the provider's website (if the provider has a website). This number must be provided to the DMH, Office of Consumer Support. Individuals in crisis should only have to dial a~~

~~single phone number for assistance. Answering services are permissible as long as the individual speaks with a trained professional. Answering machines are not permissible~~.

D. Crisis Response Services must be available 24 hours a day, 7 days a week, and 365 days a year. Crisis Response Services must have the capability to respond to multiple crisis calls at a time. Services include:
   1. A single toll-free telephone number which covers the provider's entire catchment area for crisis calls.
   2. Mobile Crisis Response capability for the provider's entire catchment area.
   3. "Walk-in" Crisis Response capability at all DMH certified service locations in the provider's catchment area.

E. The "on-call" Crisis Response staff answering the toll-free telephone number must:
   1. Ensure that a mental health representative is available to speak with an individual in crisis and/or family members/legal representatives of the individual at all times.
   2. Have the ability to triage and determine the need to deploy Mobile Crisis Response Services.
   3. Ensure individuals or family members/legal representatives of the individual in crisis should only have to call a single time to the toll-free number to request and receive assistance.

F. Crisis Response Services must coordinate with the DMH Office of Consumer Support (OCS) and respond to crisis call referrals from the OCS generated from the DMH Help Line (1-877-210-8513) or any agency DMH contracts with to provide after-hours Help Line coverage.

G. The provider must:
   1. Ensure Crisis Response Services availability is publicized, including a listing in the telephone directories for each county served by the provider and on the homepage of the provider's website.
   2. Ensure the individual speaks with a trained professional if an answering service is used after typical work hours (which is permissible.) Automated answering devices are not permissible.
   3. Ensure the provider's toll-free number is provided to DMH, Office of Consumer Support (1-877-210-8513.)

~~E. Face-to-face contact (i.e. Mobile Crisis Response) with a mental health professional twenty-four (24) hours a day, seven (7) days a week must be available. The staff person is not required to see the individual in the individual's home, but this is permissible and recommended. There must be designated, strategic, publicized locations where the person can meet with a mental health professional. The individual must be seen within one (1) hour of initial time of contact if in an urban setting and within two (2) hours of initial time of contact if in a rural setting. A team approach to mobile crisis response should be utilized if warranted to adequately address the situation.~~

H. Mobile Crisis Response Services with a mental health professional(s) must:

1. Be able to respond within one (1) hour of initial time of contact if in an urban setting and within two (2) hours of initial time of contact if in a rural setting.
2. Designate a strategic, publicized location where the person in crisis can meet with a mental health professional. The staff person is not required to see the individual in the individual's home, but this is permissible and recommended.
3. Complete an assessment of the individual's risk and acuity using an assessment tool as required by DMH. The assessment will include, but not be limited to, current risk level related to suicide/homicide, substance abuse, mental status, current and past mental health diagnoses and treatment, coping skills and medical condition.
4. Utilize a team approach to Mobile Crisis Response if warranted to adequately address the crisis situation. Law enforcement should accompany the Mobile Crisis Response Team if safety is a concern.
5. Work to immediately stabilize the individual's crisis situation using solution- focused and recovery-oriented interventions designed to avoid unnecessary hospitalization, incarceration or placement in a more segregated setting.
6. Assess current natural supports and make a determination if the individual can safely remain in the community.
7. Transport or arrange transportation to the most appropriate treatment setting if the individual is determined to be a danger to self or others.
8. Provide for the level of service the individual requires, mitigate the crisis situation and if known, support his/her long term recovery goals (ex., Crisis Support Plan, Advanced Directive.)

I. Policies and procedures must be in place which detail how "walk-in" crisis situations will be handled by Crisis Response Services. The policies and procedures must be specific to each DMH certified location in the provider's catchment area.

J. Crisis Response Services must have access to medical and psychiatric support as needed (24/7/365 days a year). Medical and psychiatric support can be provided through the use of telemedicine (i.e., computer tablet, laptop, etc.)

K. Crisis Response Services must facilitate and verify formal initial assessment and therapy appointments, when the crisis situation subsides, with the mental health provider of the individual's choice (if the individual is able to remain in the community) utilizing the "warm handoff" method. A "warm handoff" is an approach to care transitions in which health care providers directly link individuals with typical service providers, using face-to-face or phone transfer. "Warm handoff" achieves very high rates of treatment enrollment for this vulnerable group.

L. Follow-up daily and provide any necessary services to the individual between the initial stabilization of the crisis and the initiation of typical therapeutic and psychiatric care.

S. Recipients of Crisis Response Services do not have to be currently or previously enrolled in any of the services provided by the provider. Crisis Response Services may be provided to an individual before he/she participates in the initial assessment that is part of the intake/admission process.

~~F. Assessment and treatment for individuals held in a Certified Mental Health Holding Facility who are waiting for bed availability after an inpatient commitment, must be available twenty-four (24) hours a day, seven (7) days a week.~~

19.2 Crisis Response Services Staffing Requirements

A. Crisis Response Services must consist, at a minimum, of the following staff:
   1. A Certified Peer Support Specialist(s),
   2. A Licensed and/or Credentialed Master's Level Therapist(s) with experience and training in crisis response (Provisionally Licensed and/or Credentialed Therapists are excluded),
   3. A Community Support Specialist(s) with experience and training in crisis response,
   4. A Crisis Response Coordinator for the provider's catchment area. Coordinator must be a Licensed and/or Credentialed Master's Level Therapist with a minimum of two years' experience and training in crisis response.
   5. At least one staff member must have experience and training in crisis response to each population services by the provider (MH, IDD, and/or SUD).

F. ~~G.~~ There must be documentation that all staff assigned to ~~Emergency/~~Crisis Response Services are trained in the policies and procedures required for Pre-Evaluation Screening and Civil Commitment Examinations. Master's level staff must be certified to complete the Pre-Evaluation Screening for Civil Commitment.

G. ~~H.~~ All staff members providing Crisis Response Services must obtain and maintain certification in a professionally recognized method of crisis intervention and de-escalation (ex. CPI, the Mandt system or Nonviolent Crisis Intervention.) ~~such as Techniques for Managing Aggressive Behavior, the Mandt system or Nonviolent Crisis Intervention.~~

H. All staff members providing Crisis Response Services must obtain nationally recognized training for specialized mental health crisis response/intervention training (ie. Mental Health First Aid.)

G. All staff members providing Crisis Response Services must obtain nationally recognized training for suicide prevention (ie. Applied Suicide Intervention Skills Training.)

H. Crisis Response Services will provide training to all clinical co-workers regarding the development and implementation of Crisis Support Plans.

G. Crisis Response Coordinator must request to be a member of all adult and children's Multi-Disciplinary Assessment and Planning (Making A Plan) (MAP) Teams in the provider's catchment area and attend meetings regularly. If there is no local adult or children's MAP Team, the Crisis Coordinator is required to initiate the development of MAP Teams within their catchment area.

19.3 Crisis Response Service Coordination

~~I. The provider must obtain and renew annually a written interagency agreement(s) or contract(s) with all licensed hospitals in the area to provide emergency services that at a minimum address the following:~~

~~2. Training of emergency room staff in handling mental health emergencies;~~
~~3. Availability of hospital emergency room services to address the needs of individuals in crisis;~~
~~4. Availability of face-to-face contact with a mental health professional; and~~
~~5. The mental health provider's involvement in providing consultation in the care of individuals who are admitted to a hospital for medical treatment of suicide attempts or other psychiatric emergencies.~~

~~Should the licensed hospital chose not to enter into the above referenced written interagency agreement or contract, the provider must show evidence that effort was made to secure agreements with the hospital. The provider should document efforts (inclusive of contact people by name and position) related to securing such agreement(s).~~

~~J. If DMH-certified Crisis Stabilization Services are available in the area, the provider must obtain and annually renew a written interagency agreement(s) or contract(s) with the provider of Crisis Stabilization Services for assessment twenty-four (24) hours a day, seven (7) days a week. Should the provider of Crisis Stabilization Services chose not to enter into the above referenced written interagency agreement or contract, the provider must show evidence that effort was made to secure the required agreements. The provider should document efforts (inclusive of contact people by name and position) related to securing such agreement(s).~~

C. Crisis Response Services must provide crisis assessment and crisis support when requested by entities providing services to the following:
1. Individuals held in a Certified Mental Health Holding Facility who are waiting for bed availability after an inpatient commitment.
2. Individuals held in a local jail with a mental health emergency.
3. Individuals presenting in local emergency rooms with a mental health emergency.

B. Crisis Response Services must offer to all licensed hospitals with emergency departments in the catchment area:
1. Training of emergency room staff in handling mental health emergencies.
2. Consultation in the care of individuals who are admitted to the hospital for medical treatment of suicide attempts or other mental health emergencies.

C. Crisis Response Services must provide assessment and arrange transportation twenty-four (24) hours a day, seven (7) days a week to the DMH-certified Crisis Residential Services (Crisis Stabilization Unit) designated for the provider catchment area for individuals in need of Crisis Residential Services.

D. Crisis Response Services must attempt to develop a close working relationship with law enforcement (i.e. city police, county sheriff, campus police, county jails, youth detention centers, etc.) in the provider's catchment area and request appointment of officers to the provider's Mobile Crisis Response Team. The Crisis Response Coordinator must maintain documentation of contacts with these agencies.

E. Crisis Response Services will offer and provide mental health crisis response/intervention training to law enforcement agencies. The Crisis Response Coordinator must maintain documentation of the request, response and training provided.

F. Crisis Response Services will attempt to develop a close working relationship with all Chancery Courts and Clerks in the provider's catchment area. The Crisis Response Coordinator must maintain documentation of contacts with these agencies.

19.4 Crisis Response Services Documentation Requirements:

A. K. ~~Providers of Emergency/~~Crisis Response Services must maintain ~~a written, daily log of emergency/crisis face-to-face and telephone contacts,~~written documentation (ie. crisis log or list) of all crisis response contacts (face-to-face and telephone contacts), including, at a minimum:

1. Identification of the individual in crisis.
2. Time and date contact was made.
3. Type of contact (face-to-face contact and/or telephone contact.)
4. The location of contact, if it was face-to-face.
5. Name of the staff member(s) addressing the emergency/crisis.

~~2. Time and date the individual and/or family member/legal representative contacted the provider;~~
~~3. Time and date of emergency face-to-face contact and/or telephone contact;~~
~~4. The location of contact, if it was face-to-face;~~
~~5. Presenting problem(s);~~
~~6. Action(s) taken by emergency services staff;~~
~~7. Documentation of notification and involvement of significant others, and if contact is deemed inappropriate, indication of why there was no notification;~~
~~8. Disposition or resolution of the emergency/crisis, including:~~
~~(a) Condition of the individual(s) at the last face-to-face contact and/or termination of the telephone call~~
~~(b) Services to which the individual and/or family was referred~~
~~9. Name and credentials of staff member(s) addressing the emergency/crisis.~~

B. A Crisis Contact Summary as described in the DMH Record Guide must be completed for each individual in which Crisis Response Services are provided.

C. Crisis Response Services will submit data as determined and required by the Department of Mental Health.

~~Rule 19.2 Intensive Crisis Intervention for Children and Youth with an SED~~

~~A. Intensive Crisis Intervention Services for Children and Youth with an SED are specialized, time limited interventions that last for 6-8 weeks and include intensive outpatient mental health therapy services and in-home services and support for the family or other caregivers. These services are available twenty-four (24) hours a day, seven (7) days/week.~~

~~B. Providers of Intensive Crisis Intervention Services, must also comply with Emergency/Crisis Response Services standards in Rule 19.1~~

~~C. Providers of Intensive Crisis Intervention Services must, at a minimum, provide access to Community Support Services and Outpatient Mental Health Therapy Services.~~

~~D. Providers must include documentation in the child/youth's record that he/she has entered Intensive Crisis Intervention Services and must have a plan in place for transition out of Intensive Crisis Intervention services.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

Rule ~~19.3~~ 19.5 Crisis Stabilization Services – Crisis Stabilization Units

C. Crisis Stabilization Services are time-limited residential treatment services provided in a Crisis Stabilization Unit which provides psychiatric supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of acute psychiatric distress which severely impairs their ability to cope with normal life circumstances. Crisis Stabilization Services must be designed to prevent civil commitment and/or longer term inpatient psychiatric hospitalization by addressing acute symptoms, distress and further decomposition. Crisis Stabilization Services content may vary based on each individual's needs but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

D. Crisis Stabilization Services may be provided to children/youth with serious emotional/behavioral disturbance or adults with a serious and persistent mental illness.

C. Children receiving Crisis Stabilization Services must be a minimum of six (6) years of age. Children/youth up to age eighteen (18) cannot be served in the same facility as adults.

D. Crisis Stabilization Services must be designed to accept admissions (voluntary and involuntary) twenty-four (24) hours per day, seven (7) days per week.

E. Crisis Stabilization Services must provide the following within twenty-four (24) hours of admission to determine the need for Crisis Stabilization Services and to rule out the presence of mental symptoms that are judged to be the direct physiological consequence of a general medical condition and/or illicit substance/medication use;

1. Initial assessment
2 Medical screening
3. Drug toxicology screening
4. Psychiatric consultation

F. Crisis Stabilization Services must consist of;

1. Evaluation
2. Observation
3. Supportive ~~Crisis~~ counseling
4. Substance abuse counseling
5. Individual, Group and Family Therapy
6. Targeted Case Management and/or Community Support Services
7. Family Education
8. Therapeutic Activities (i.e., recreational, psycho-educational, social/interpersonal)

G. Direct services (i.e., Supportive counseling, therapy, recreational, psycho-education, social/interpersonal activities) can be provided seven (7) days per week but must at a minimum be;

1. Provided five (5) days per week.
2. Provided five (5) hours per day.
3. Provided two (2) hours per day for children/youth if attending school.

H. A daily schedule must be maintained and posted in a prominent location. The schedule must show the entire day (24 hours).

L. Crisis Stabilization Services must also provide adequate nursing and psychiatric services to all individuals served. At a minimum, these services must be provided every seven (7) days (or more often if clinically indicated).

M. An initial individual therapy session must be provided to each individual admitted within the first seventy-two (72) hours of his/her admission.

N. Prior to discharge from Crisis Stabilization Services, an appointment must be made for the individual to begin or continue services from the local Community Mental Health Center or other mental health provider.

N. Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site director.

O. Crisis Stabilization Services must have a full-time (forty (40) hours per week) on-site mental health therapist.

N. Crisis Stabilization Services must maintain at least a one (1) direct service staff to four (4) residents ratio twenty-four (24) hours per day, seven (7) days per week. A Registered Nurse must be on-site during all shifts and may be counted in the required staffing ratio.

O. All Crisis Stabilization Services staff must successfully complete training and hold certification in a nationally recognized or DMH-Approved Program for managing aggressive or risk-to-self behavior.

P. The DMH only allows seclusion to be used in Crisis Stabilization Services with individuals over the age of eighteen (18.) Time-Out may be utilized for individuals under the age of 18.

Q. If a program uses a room for seclusion(s), the program must be inspected by DMH and obtain written approval of the use of such room from the DMH Review Committee prior to its use for seclusion. A room must meet the following minimum specifications in order to be considered for approval by the DMH for use in seclusion:

1. Be constructed and located to allow visual and auditory supervision of the individual
2. The dimensions of the room must be at least forty-eight (48) square feet
3. Be suicide resistant and have break resistant glass (if any is utilized in the room or door to the room).

R. CSU providers utilizing seclusion must establish and implement written policies and procedures specifying appropriate use of seclusion. The policies and procedures must include, at a minimum:

1. Clearly define seclusion and the appropriate conditions and documentation associated with its use. Seclusion is defined as behavioral control technique involving locked isolation. This does not include a time-out.
2. Require that seclusion is used only in emergencies to protect the individual from injuring himself/herself or others. "Emergency" is defined as a situation where the individual's behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, staff, or others.
3. Require that seclusion is used only when all other less restrictive alternatives have been determined to be ineffective to protect the individual or others from harm and documented in the individual's case record.
4. Require that seclusion is used only in accordance with the order of a physician or other licensed independent practitioner, as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider. This order must be documented in the case record. The following requirements must be addressed in the policies and procedures regarding the use and

implementation of seclusion and implementation (as applicable) and be documented in the individual case record:

(a) Orders for the use of seclusion must never be written as a standing order or on an as needed basis (that is, PRN)
(b) The treating physician must be consulted as soon as possible, if the seclusion is not ordered by the individual's treating physician
(c) A physician or other licensed independent practitioner must see and evaluate the need for seclusion within one (1) hour after the initiation of seclusion
(d) Each written order for seclusion must be limited to four (4) hours. After the original order expires, a physician or licensed independent practitioner (as permitted by State licensure rules/regulations governing scope of practice of the independent practitioner and the provider) must see and assess the individual in seclusion before issuing a new order
(e) Seclusion must be in accordance with a written modification to the Individual Service Plan of the individual being served
(f) Seclusion must be implemented in the least restrictive manner possible
(g) Seclusion must be in accordance with safe, appropriate techniques
(h) Seclusion must be ended at the earliest possible time.

5. Requirements that seclusion is not used as a form of punishment, coercion, or staff convenience.
6. Requirements that all staff which have direct contact with individuals being served must have ongoing education and training in the proper, safe use of seclusion.
7. Requirements that trained staff (as described above) observe the individual and record such observation at intervals of fifteen (15) minutes or less and that they record the observation in a behavior management log that is maintained in the case record of the individual being served.
8. Requirements that the original authorization order of the seclusion may only be renewed for up to a total of twenty-four (24) hours by a licensed physician or licensed independent practitioner, if less restrictive measures have failed.

S. DMH states, "Providers are prohibited from the use of chemical restraints." A chemical restraint incapacitates an individual rendering them unable to function as a result of the medication. However, a therapeutic agent may be used to treat behavioral symptoms during a crisis. The therapeutic agent can be used to calm agitation, to help the individual concentrate, and make him/her more accessible to interpersonal intervention. Regardless of indication, medication administration during a crisis must be preceded by an appropriate clinical assessment and documentation of the assessment must be maintained in the individual's record.

T. An "as needed," prescription for a therapeutic agent at admission for all individuals is prohibited. If the clinical assessment at admission indicates the need for a therapeutic agent then it may be administered. A verbal approval for the use of a therapeutic agent by the psychiatrist or psychiatric nurse practitioner must be documented in the record as soon as possible.

U. Smoking is not permitted within ten (10) feet of the entrance of a Crisis Stabilization Unit.

V. All Crisis Stabilization Service providers must conduct an assessment, at least annually, of the following;

1. Evaluation of the level of observation that is required for all individuals receiving services at the Crisis Stabilization Unit. Policy and procedures should allow for assessment upon admission and at regular intervals during the course of treatment. If the assessment or clinical judgement indicates a greater frequency of observation is necessary, policies and procedures should reflect those practices. Policy and procedures should identify who is responsible for conducting the assessment (s).
2. Review of the physical environment of care to assess for potential risks and /or access to lethal means. Mitigation efforts must be put into place when risks are identified.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule ~~19.4~~ 19.6 Environment and Safety for Crisis Stabilization Units

E. This rule applies to environmental and safety requirements that are in addition to or more stringent than the requirements in Chapter 13 and are specific to Crisis Stabilization Units. CSUs must have procedures in place to routinely assess for access to potential lethal means and eliminate such risks.

F. The provider must assign, maintain and document on-site staff coverage twenty-four (24) hours a day and seven (7) days a week with a staff member designated as responsible for the program at all times and male/female staff coverage when necessary.

G. All providers must ensure that programs have furnishings that are safe, comfortable, appropriate, and adequate.

H. All providers must ensure adequate visiting areas are provided for residents and visitors.

~~1. Programs serving less than twelve (12) residents must have at least one (1) visiting area;~~
~~2. Programs serving thirteen (13) or more persons must have two (2) visiting areas;~~
~~3. Each visiting area must have at least two (2) means of escape.~~

E. All providers must ensure the laundry room has an exterior ventilation system for the clothes dryer.

F. All ~~programs~~ providers must have separate storage areas for:

1. Sanitary linen;
2. Food (Food supplies cannot be stored on the floor); and

3. Cleaning supplies.

G. All ~~programs~~ providers must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

H. All ~~programs~~ CSUs of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system;

I. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas;

J. ~~Programs~~ CSUs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas;

K. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom;

L. Two (2) means of exit per ~~living~~ common area must be provided and must be readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition.

M. ~~Programs~~ CSUs must have the capacity to monitor unauthorized entrance, egress, or movement through the facility; and,

N. ~~Programs~~ CSUs must have emergency exit doors operated by a magnetic/electronic (or similar) release system. This system must be in place for all doors with signage identifying the door as an emergency exit. The system must be in a readily accessible and secure location that only staff can access.

O. ~~Resident~~ CSU bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor.

P. ~~Resident~~ CSU bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

Q. ~~Resident~~ CSU bedrooms must house no more than ~~three (3)~~ two (2) persons each;

R. ~~Resident~~ CSU bedrooms must be appropriately furnished with a minimum of a single bed per resident. ~~and chest of drawers and~~ ~~a~~ Adequate storage~~/closet space~~ must be provided for each resident;

S. ~~Resident~~ CSU bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances;

T. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and

U. Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

V. All ~~programs~~ CSUs must have a bathroom(s) with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

Z. All ~~programs~~ CSUs must ensure bathtubs and showers are equipped with suicide resistant:

1. Soap dishes;
2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

AA. Providers must develop policies regarding pets and animals on the premises for all community living programs.

BB. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals receiving services as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

Rule 19.7 Crisis Stabilization Unit Orientation

A. In addition to information contained in the provider's policy and procedure manual, providers of Crisis Stabilization Services must develop an orientation package which includes policies and procedures for the provision of Crisis Stabilization Services. The orientation package is to be provided to the individual/parent/legal representative during orientation. Orientation may need to be delayed until the individual is stable enough to comprehend the information being provided.

B. All providers of Crisis Stabilization Services must document that each individual (and/or parent/guardian) being served is provided with an orientation as soon as it is appropriate based on the functioning of the individual.

C. The service and site-specific orientation package must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative.

D. Crisis Stabilization Services providers must have a written plan for providing the orientation package information in a individual's language of choice when necessary.

E. The Crisis Stabilization Services' orientation package must not simply be a book of rules. The orientation package must include the expectations of Crisis Stabilization Services and how the individual can be successful in the service.

F. At a minimum, the Crisis Stabilization Services' orientation package must address the following:

1. A person friendly, person first definition and description of the service being provided;
2. The philosophy, purpose and overall goals of the service
3. A description of how Crisis Stabilization Services addresses the following items, to include but not limited to:
   (a) Visitation guidelines (as they apply to family, significant others, friends and other visitors).
      (1) Individual's right to define their family and support systems for visitation purposes unless clinically/socially contraindicated
      (2) All actions regarding visitors (restrictions, defining individual and family support systems, etc.) must be documented in the individual's case record
      (3) Visitation rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.
   (b) Daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated
      (1) Any restrictions on private telephone use must be reviewed daily
      (2) All actions regarding restrictions of outside communication must be documented in the case record
      (3) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.
   (c) Dating
   (d) Off-site activities
   (e) Housekeeping tasks
   (f) Use of alcohol, tobacco and other drugs
   (g) Respecting the rights of other residents' privacy, safety, health and choices.
4. Policy regarding the search of the individual's room, person and/or possessions to include but not limited to;
   A. Circumstances in which a search may occur;

B. Staff designated to authorize searches;
C. Documentation of searches; and
D. Consequences of discovery of prohibited items.

5. Policy regarding screening for prohibited/illegal substances to include but not limited to:
   (a) Circumstances in which screens may occur;
   (b) Staff designated to authorize screening;
   (c) Documentation of screening;
   (d) Consequences of positive screening of prohibited substances;
   (e) Consequences of refusing to submit to a screening; and
   (f) Process for individuals to confidentially report the use of prohibited substances prior to being screened.
7. Methods for assisting individuals in arranging and accessing ~~routine and~~ emergency medical and dental care
   (a) Agreements with local physicians, hospitals and dentists to provide emergency care
   (b) Process for gaining permission from parent/guardian, if necessary.

G. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights

H. Determination of the need for and development, implementation and supervision of behavior change/management programs;

I. Description of how risks to health and safety of individuals in the program are assessed and the mitigation strategies put in place as a result of assessment; and,

J. Criteria for termination\discharge from Crisis Stabilization Services.

K. Providers of Crisis Stabilization Services must also address:

1. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided. This must include development of a menu that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.
2. Personal hygiene care and grooming, including any assistance that might be needed;
3. Medication management (including storing and dispensing); and,
4. Prevention of and protection from infection, including communicable diseases.

Rule ~~19.5~~ 19.8 ID/DD Waiver Crisis Intervention Services

O. Crisis Intervention provides immediate therapeutic intervention, available to an individual on a 24-hour basis, to address personal, social, and/or behavioral problems which otherwise are likely to threaten the health and safety of the individual or others

and/or may result in the individual's removal from his/her current living arrangement.

P. Crisis Intervention Services are used in situations in which the need is immediate and exceeds the scope of Behavior Support Services.

Q. This service is provided on a 1:1 staff to individual ratio.

R. There are three models and primary service locations: 1) Crisis Intervention in the individual's home 2) Crisis Intervention provided in an alternate community living setting or 3) Crisis Intervention provided in the individual's usual day setting.

1. Individual's home – The provider will provide or coordinate support services with the individual's ~~residential~~ community living and day services provider(s). These services will, to the greatest extent possible, allow the individual to continue to follow his/her daily routine in the service setting, with accommodations consistent with the Crisis Intervention Plan and the individual's current behaviors. The Crisis Intervention Plan indicates any adaptations/changes needed in the environments in which the individual typically spends his/her days. The Crisis Intervention staff will train and model activities and methods for day and ~~residential~~ community living staff, family members and other caregivers in order minimize the current crisis as well as prevent future occurrences.

2. Alternate residential setting – In the event an individual needs to receive Crisis Intervention services in a setting away from his/her primary residence, the provider must have pre-arranged for such a setting to be available. This may be an apartment, motel or a bedroom at a different DMH certified residence. The Crisis Intervention staff, to the greatest extent possible, maintains the individual's daily routine and follows the Crisis Intervention Plan to transition the individual back to his/her primary residence. The Crisis Intervention Plan indicates any adaptations/changes needed in the environments in which the individual typically spends his/her days.

3. Individual's usual day setting - Crisis Intervention staff will deliver services in such a way as to maintain the individual's normal routine to the maximum extent possible, ~~This includes~~ including direct support during Day Services-Adult, Prevocational Services, or Supported Employment. Other ID/DD Waiver services cannot be reimbursed while someone is receiving Crisis Intervention Services. ~~These services may be provided at the same time as Crisis Intervention.~~

S. The provider must develop policies and procedures for locating someone to an alternate residential setting(s). ~~must be submitted to DMH Behavior Services Oversight Team within thirty (30) days of the agency's approval to provide the service.~~ This includes the type of location, whether individuals will be alone or with others, and plans for transporting individuals. The ~~plan~~ policies and procedures must include a primary and secondary means for providing an alternate residential setting(s). These settings must be equipped with all items necessary to create a home like environment for the individual.

T. The provider must have an on-call system that operates 24 hours a day, seven (7) days per week to ensure there is sufficient staff available to respond to crises.

U. Providers of Crisis Intervention shall consist of a team (see Rule 11.4 for qualifications) which must include:

1. Licensed Psychologist
2. Program Director
3. QIDP
4. Direct service staff

V. Crisis Intervention Services are approved on an individual's Plan of Services and Supports when there is a reasonable expectation, based on past occurrences or immediate situational circumstances in which the individual is at risk of causing physical harm to him/herself, causing physical harm to others, damaging property, eloping, or being unable to control him/herself in a manner that allows participation in usual activities of daily life. The provider will be chosen at the time the service is approved on the Plan of Services and Supports; therefore, if a crisis arises, the provider can be dispatched immediately.

W. Upon receiving information that someone is in need of Crisis Intervention, the provider immediately sends trained staff to the individual to assess the situation and provide direct intensive support when an individual is physically aggressive or there is concern that the individual may take actions that threaten the health and safety of self and others.

X. As soon as is feasible, the individual must be evaluated by medical personnel to determine if there are any physical/medication factors affecting his/her behavior.

Y. When the immediate crisis is stabilized, appropriately qualified staff:

1. Continue analyzing the psychological, social and ecological components of the extreme dysfunctional behavior or other factors contributing to the crisis
2. Assess which components are the most effective targets of intervention for the short-term amelioration of the crisis
3. Develop and write a Crisis Intervention Plan
4. Consult and, in some cases, negotiate with those connected to the crisis in order to implement planned interventions, and follow-up to ensure positive outcomes from interventions or to make adjustments to interventions
13. Continue providing intensive direct supervision/support
14. Assist the individual with self-care when the primary caregiver is unable to do so because of the nature of the individual's crisis situation
15. Directly counsel or develop alternative positive experiences for individuals while planning for the phase out of Crisis Intervention services and return of the individual to his/her living arrangement, if applicable

16. Train staff and other caregivers who normally support the individual in order to remediate the current crisis as well as to support the individual long term once the crisis has stabilized in order to prevent a reoccurrence.

Z. Crisis Intervention staff may remain with the person 24/7 until the crisis is resolved; Crisis Intervention is authorized ~~by the DMH Behavior Services Oversight Team~~ for up to 24 hours per day in seven (7) day segments with the goal being a phase out of services in a manner which ensures the health and welfare of the individual and those around him/her. Additional seven (7) day segments will be authorized, depending on individual need and situational circumstances.

AA. Episodic Crisis Intervention is provided in short term (less than 24 hours) segments and is intended to address crises such as elopement, immediate harm to self or others, damage to property, etc. that can be managed through less intensive measures than daily Crisis Intervention.

BB. ~~M.~~ If an individual requires a higher level of supervision/support than can be safely provided through Crisis Intervention services, he/she will be appropriately referred to other more intensive services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule ~~19.6~~ 19.9 ID/DD Waiver Crisis Support Services

A. Crisis Support is provided in an ICF/IID and is used when an individual's behavior or family/primary caregiver situation becomes such that there is a need for immediate specialized services that exceed the capacity of Crisis Intervention or Behavior Support services.

B. Individuals cannot be admitted to an ICF/IID without prior approval from BIDD. ~~the DMH.~~

C. Crisis Support is provided a maximum of thirty (30) days. Additional days must be prior authorized by ~~the Director of~~ BIDD. ~~or the DMH Behavior Services Oversight Team.~~

D. Providers must follow all applicable state and federal ICF/IID regulations related to the use of seclusion or restraint.

E. Individuals receiving Crisis Support services can be transitioned back to their regular daily activities/living arrangements, but other ID/DD Waiver services cannot be reimbursed while someone is receiving Crisis Support.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 20: Community Support Services

Rule 20.1 Community Support Services – General

I. Community Support Services provide an array of support services delivered by community-based, mobile Community Support Specialists. CSS are only provided by certified DMH/C and DMH/P providers. CSS are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS should be focused on the individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work, family, community participation. ~~integration~~.

J. Community Support Services should be person-centered and focus on the individual's recovery and ability to succeed in the community; to identify and access needed services; and to show improvement in home, health, purpose and community. Community Support Services shall include the following:

1. Identification of strengths which will aid the individual in their recovery and the barriers that will challenge the development of skills necessary for independent functioning in the community.
2. Individual therapeutic interventions with a beneficiary that directly increase the acquisition of skills needed to accomplish the goals set forth in the Individual Service Plan.
3. Monitoring and evaluating the effectiveness of interventions, as evidenced by symptom reduction and progress toward goals.
4. Psychoeducation on the identification and self-management of prescribed medication regimen and communication with the prescribing provider.
5. Direct interventions in deescalating situations to prevent crisis.
6. Assisting an individual in accessing needed services such as medical, social, educational, transportation, housing, substance abuse, personal care, employment and other services that may be identified in the ~~CSS Activity Plan~~ Recovery Support Plan as components of Health, Home, Purpose and Community.
8. Assisting the ~~beneficiary~~ individual and natural supports in implementation of therapeutic interventions outlined in the Individual Service Plan.
9. Relapse prevention and disease management strategies.
10. Psychoeducation and training of family, unpaid caregivers, and/or others who have a legitimate role in addressing the needs of the individual.
11. Facilitation of the Individual Service Plan and/or ~~CSS Activity Plan~~ Recovery Support Plan which includes the active involvement of the beneficiary and the people identified as important in the person's life.

K. Providers of CSS must, at a minimum:

1. Have a designated Director of CSS to supervise the provision of CSS.
2. Assign a full time, DMH Credentialed Community Support Specialist for each individual enrolled in the service.
3. Maintain a list of each Community Support Specialist's caseload that must be available for review by DMH staff.
4. Maintain a current, comprehensive file of available formal and informal supports that is readily accessible to all Community Support Specialists.
5. Electronically maintained resource information is permissible. This resource file must include at a minimum:
   (a) Name of entity
   (b) Eligibility requirements (if applicable)
   (c). Contact person
   (d) Services and supports available
   (e) Phone number.

L. The following priority groups of individuals with serious mental illness, children/youth with serious emotional disturbance and individuals with an intellectual or developmental disability must be offered CSS within fourteen (14) days of the date of his/her Initial Assessment. CSS must be provided within fourteen (14) days of the Initial Assessment unless the individual states, in writing, that he/she does not want to receive the service.

   1. Individuals discharged from an inpatient psychiatric facility;
   2. Individuals discharged from an institution;
   3. Individuals discharged or transferred from Crisis Stabilization Services; and
   4. Individuals referred from Emergency/Crisis Response Services.

M. Individuals with serious mental illness, serious emotional disturbance and/or an intellectual/developmental disability not included in these priority groups should be assessed to determine the need for CSS within thirty (30) days of his/her Initial Assessment. CSS must be provided within thirty (30) days of the Initial Assessment if the assessment indicates a need for such, unless the individual states, in writing, that he/she does not want to receive the service.

N. Caseloads of Community Support Specialists must not exceed eighty (80) individuals receiving services.

O. Frequency of the provision of Community Support Services should be based on the needs of the individual receiving the service.

P. The ~~Community~~ Recovery Support ~~Activity~~ Plan must clearly state and justify the frequency of contact.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 20.2 Community Supports for Adults with SMI

A. Providers of Community Support Services for Adults with SMI must also adhere to Rule 20.1.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 20.3 Community Support Services for Children/Youth with SED

A. Providers of Community Support Services for Children/Youth with SED must also adhere to Rule 20.1.

~~B. The Community Support Specialist must document all efforts to, at a minimum; include the following representatives in the development of the Community Support Plan:~~

~~1. Representative(s) of the Mississippi Department of Human Services (DHS) for children/youth in DHS custody or under their supervision~~
~~2. Representative(s) of the child's/youth's local school.~~

D. Input from the parent(s)/legal representative(s) in the development of the ~~Community Support Activity~~ Recovery Support Plan for children/youth must be documented.

E. The case load for a single Community Support Specialist providing services to children, youth, and transition-age youth enrolled in federal System of Care grants must not exceed twenty-five (25).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 20.4 Community Support Services for Individuals with Intellectual/Developmental Disabilities – Adults and Children

C. Providers of Community Support Services for Individuals with and IDD must also adhere to Rule 20.1.

D. Community Support Services for this population must target individuals who are dually diagnosed with a serious mental illness or serious emotional disturbance and an intellectual/developmental disability. Community Support Services for this population must focus on rehabilitation efforts that target an individual's ability to succeed in the community; to identify and access needed services; and to show improvement in school, work and family; and community integration.

~~C. Face-to-face contact must, at a minimum, be conducted on a quarterly basis with each individual receiving service.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 21: Psychiatric/Physician Services

Rule 21.1 Psychiatric/Physician Services

A. Psychiatric/Physician's Services are services of a medical nature provided by medically trained staff to address medical conditions related to the individual's mental illness or emotional disturbance. Medical services include medication evaluation and monitoring, nurse assessment, and medication injection.

B. If indicated by the Initial Assessment, the following priority groups of individuals with serious mental illness, children/youth with serious emotional disturbance and individuals with an intellectual or developmental disability (if applicable) must be ~~offered~~ provided Psychiatric/Physician's Services within fourteen (14) days of the date of his/her Initial ~~Biopsychosocial~~ Assessment~~. Psychiatric/Physician's Services must be provided within fourteen (14) days of the Initial Biopsychosocial Assessment~~ unless the individual states, in writing, that he/she does not want to receive the service. Appointment cancellations or "no shows" must be documented in the individual's case record.

5. Individuals discharged from an inpatient psychiatric facility;
6. Individuals discharged from an institution;
7. Individuals discharged or transferred from Crisis Stabilization Services; and,
8. Individuals referred from ~~Emergency/~~Crisis Response Services.

C. Medication Evaluation and Monitoring is the intentional face-to-face interaction between a physician or a nurse practitioner and an individual for the purpose of: assessing the need for psychotropic medication, prescribing medications, and regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety.

D. Nursing assessment takes place between a registered nurse and an individual for the purpose of assessing extra-pyramidal symptoms, medication history, medical history, progress on medication, current symptoms, progress or lack thereof since last contact and providing education to the individual and the family about the illness and the course of available treatment.

E. Medication injection is the process of a licensed practical nurse, registered nurse, physician, or nurse practitioner injecting an individual with prescribed psychotropic medication for the purpose of restoring, maintaining or improving the individual's role performance and/or mental health status.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 22: Outpatient Therapy Services

Rule 22.1 Psychotherapeutic Services

A. Outpatient Psychotherapeutic Services include initial assessment, and individual, family, group, and multi-family group therapies. Outpatient Psychotherapeutic Services are defined as intentional, face-to-face interactions (conversations or non-verbal encounters, such as play therapy) between a mental health therapist, IDD therapist or A/D therapist (as appropriate to the population being served) and an individual, family or group where a therapeutic relationship is established to help resolve symptoms of a mental and/or emotional disturbance.

B. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and the individual receiving services.

C. Family Therapy shall consist of psychotherapy that takes place between a mental health therapist and an individual's family members with or without the presence of the individual. Family Therapy may also include others (DHS staff, foster family members, etc.) with whom the individual lives or has a family-like relationship. This service includes family psychotherapy and psychoeducation provided by a mental health therapist.

H. Group Therapy shall consist of psychotherapy that takes place between a mental health therapist and at least two (2) but no more than ten (10) children or at least two (2) but not more than twelve (12) adults at the same time. Possibilities include, but are not limited to, groups that focus on relaxation training, anger management and/or conflict resolution, social skills training, and self-esteem enhancement.

E. Multi-Family Group Therapy shall consist of psychotherapy that takes place between a mental health therapist and family members of at least two (2) different individuals receiving services, with or without the presence of the individual, directed toward the reduction/resolution of identified mental health problems so that the individual and/or their families may function more independently and competently in daily life. This service includes psychoeducational and family-to-family training.

F. Outpatient Psychotherapeutic services must be available and accessible at appropriate times and places to meet the needs of the population to be served. The provider must establish a regular schedule, with a minimum of three (3) hours weekly for the provision of Outpatient Psychotherapeutic services during evenings and/or weekends.

G. Providers utilizing Evidence Based Practices (EBP) or best practices in the provision of Outpatient Psychotherapeutic Services must show verification that staff members utilizing those practices have completed appropriate training or independent study as recommended by the developers of the model/practice for the practices being utilized.

H. For DMH/C providers of Outpatient Psychotherapeutic Services for Children/Youth: At least, one outpatient therapist must be offered to each public school district in the region served by the CMHC. If the school district does not accept the provider's offer to provide outpatient psychotherapeutic services, written documentation of the denial (for the current school year) by the school district superintendent must be on file at the CMHC for review by DMH personnel.

I. There must be written policies and procedures for:

1. Admission
2. Coordination with other services in which the individual is enrolled
3. Follow-up designed to minimize dropouts and maximize treatment compliance
4. Therapist assignments
5. Referral to other appropriate services as needed; and
6. Discharge planning.

~~J. The provider must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that:~~

~~1. Provide a phone number where contact can be made to arrange for an appointment;~~
~~2. Assure the person requesting services only has to make one call to arrange an appointment.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

<u>Rule 22.2 Intensive Outpatient Psychiatric Services for Children/Youth with SED</u>

G. Intensive Outpatient Psychiatric (IOP-C/Y) services are defined as treatment provided in the home or community to children and youth with serious emotional disturbance up to the age of twenty-one (21) for family stabilization. Based on a wraparound model, this service is a time-limited, intensive family intervention intended to diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. The ultimate goal is to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).

H. In order to receive IOP services, individuals must meet all the following criteria:

1. The youth has been diagnosed by a psychiatrist or licensed psychologist in the past sixty (60) days with a mental, behavioral or emotional disorder of sufficient duration to meet diagnostic criteria for Serious Emotional Disturbance (SED) specified within the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM). The primary diagnosis must be psychiatric.

2. The youth has a full scale IQ of sixty (60) or above (or, if IQ score is lower than sixty (60) and there is substantial evidence that the IQ score is suppressed due to psychiatric illness).
3. The evaluating psychiatrist or licensed psychologist advises that the youth meets criteria for PRTF level of care.
4, The youth needs specialized services and supports from multiple agencies including community support services or targeted case management, and an array of clinical interventions and family supports.

I. Providers of Intensive Outpatient Psychiatric Services must meet the following requirements:

7. Hold certification by DMH to provide Community Support Services and wraparound facilitation;
8. Have a psychiatrist on staff;
9. Have appropriate clinical staff to provide therapy services needed;
10. Coordinate services and needed supports with other providers and/or natural supports when appropriate and with consent;
11. Provide education on wellness, recovery and resiliency;
6. Providers must have procedures in place for twenty-four (24) hour, seven (7) days a week availability and response (inclusive of mobile crisis response services).

J. IOP-C/Y must be provided to children/youth based on the child/youth's needs as identified as a part of the wraparound or individual plan.

K. IOP-C/Y is an all-inclusive service designed to meet the clinical needs of the children/youth and families. Component parts of IOP must also be certified by DMH if applicable certification is available.

L. Each beneficiary receiving IOP-C/Y must have on file an individualized plan which describes the following:

1. Services to be provided;
2. Frequency of service provision;
3. Who provides each service and their qualifications;
4. Formal and informal supports available to the participant and family; and
3. Plan for anticipating, preventing and managing crises.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 22.3 Intensive Outpatient Programs for ~~Individuals~~ Adults with a Substance ~~Abuse~~ Use Disorder

D. The 10-week Intensive Outpatient Program for Individuals with a Substance ~~Abuse~~ Use Disorder (IOP-~~A/D~~SUD) is a community-based outpatient program which provides an alternative to traditional Residential Treatment Services or hospital settings. The

program is directed to ~~persons~~ adults 18 year or older who need services more intensive than traditional outpatient services, but who have less severe alcohol and other drug disorders than those typically addressed in Residential Treatment Services. The IOP-~~A/D~~ SUD allows individuals to continue to fulfill their obligations to family, job, and community while obtaining intensive treatment. IOP-~~A/D~~SUD may be conducted during the day or at night in order to meet the needs of the Individuals being served.

E. IOP-~~A/D~~ SUD must be limited to twelve (12) individuals per session.

F. IOP-~~A/D~~ SUD must provide the following services:

1. Group therapy for a minimum of three (3) sessions per week ~~nights a week for three (3) hours each night~~ for at least ten (10) weeks. Sessions times may vary but cannot be less than one hour and cannot exceed three hours daily. Individuals must receive and not exceed 9 total hours of group therapy per week. Groups may be of the following types: Psychoeducational groups, Skills-development groups, Drug or alcohol refusal training, Relapse prevention techniques, Assertiveness training, Stress management, Support groups (e.g., process-oriented recovery groups), Single-interest groups (can include gender issues, sexual orientation, criminal offense, and histories of physical and sexual abuse) family or couples groups.
2. Individual therapy at a minimum of one (1) counseling session, for a minimum of one hour, per week; and
3. Involvement of family to include no less than two (2) therapeutic family group sessions during the ten (10) week period, offered to meet the needs of the individual.

Rule 22.4 Intensive Outpatient Programs for Adolescents with a Substance Use Disorder

A. Adolescent-Intensive Outpatient Program (A-IOP) is a community-based outpatient program which provides an alternative to traditional Residential Treatment Services or hospital settings. The program is directed to adolescents ages 12-18 who need services more intensive than traditional outpatient services, but who have less severe alcohol and other drug disorders than those typically addressed in Residential Treatment Services. The A-IOP allows individuals to continue to fulfill their obligations to family, job, school, and community while obtaining treatment. A-IOP is primarily conducted in the evening, but may be offered at in varying locations and times to suit the needs of the adolescents being served.

B. A-IOP must be limited to twelve (12) individuals per session.

C. A-IOP must provide the following services:

5. Group therapy must be offered over the course of at least 10 weeks for 6.5 hours per week. Times and locations for groups may vary based on the needs of the adolescents being served. Groups may be of the following types: Psychoeducational groups, Skills-development groups, Drug or alcohol refusal training, Relapse prevention techniques, Assertiveness training, Stress management, Support groups (e.g., process-

oriented recovery groups), Single-interest groups (can include gender issues, sexual orientation, criminal offense, and histories of physical and sexual abuse) family or couples groups.

6. Individual therapy at a minimum of one (1) counseling session, for a minimum of one hour, per week; and
7. Involvement of family to include no less than two (2) therapeutic family group sessions during the ten (10) week period, offered to meet the needs of the individual.
8. Providers utilizing Evidence-Based Practices (EBP) or best practices in the provision of A-IOP must show verification that staff members utilizing those practices have completed appropriate training or independent study as recommended by the developers of the model/practice for the practices being utilized.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 23: ~~Day Programs for Children~~ Acute Partial Hospitalization Services for Children with SED, ~~and~~ Adults with SMI and Partial Hospitalization Programs for Adults or Children with Substance Use Disorders

Rule 23.1 Acute Partial Hospitalization Services to Children with SED or Adults with SMI

A. Acute Partial Hospitalization Services (APH) provide medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. APH is designed to provide an alternative to inpatient hospitalization for such individuals or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. APH may be provided to children with serious emotional disturbance or adults with serious and persistent mental illness.

B. The APH program must be a part of a written comprehensive plan of crisis stabilization and community-based support services offered to individuals participating in the APH program that includes, at a minimum, family intervention, Targeted Case Management, medication monitoring, Crisis Response Services and Community Support Services. The APH program must be designed to assist individuals in making the transition from acute inpatient services, and/or serve as an alternative to inpatient care.

C. There must be written policies and procedures implemented for providing APH that include at a minimum:

   1. Admission criteria and procedures. These procedures must require that a physician conduct an admission evaluation and certify that the service is required to reduce or prevent inpatient services.
   2. Procedures requiring documented medical supervision and follow along with on-going evaluation of the medical status of the individual.
   3. Procedures requiring documented support services for families and significant others.
   4. Procedures implementing and documenting discharge criteria to include follow-up planning.

D. The staff for APH Services must include at each site a full time director who plans, coordinates, and evaluates the program.

E. APH Services staff must meet the following minimum requirements:

   1. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field must be on-site for six (6) or fewer persons for which the program is certified to serve. The staff can be the on-site Program Director if he/she is actively engaged in programmatic activities with individuals during all program hours.

2. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field and at least one (1) staff with a minimum of a Bachelor's degree in a mental health or related field when seven (7) through twelve (12) participants are served.
3. At least one (1) staff with a minimum of a Master's degree in a mental health or related field, at least one (1) staff with a minimum of a Bachelor's degree in a mental health or related field and least one (1) support staff when thirteen (13) through eighteen (18) participants are served in the program.

F. The APH Program must provide adequate nursing and psychiatric services to all individuals served. At a minimum, these services must be provided weekly (and more often if clinically indicated). Provision of these services must be documented through an implemented written procedure carried out by the ~~CMHC~~ provider or through contractual agreement.

G. Medical supervision and nursing services must be immediately available and accessible to the program during all hours of operation.

H. The APH Program can be operated seven (7) days per week, but must at minimum:

1. Operate three (3) days per week.
2. Operate four (4) hours per day, excluding transportation time.
3. Be available twelve (12) months per year.

I. The APH Program must be designed for a maximum number of eighteen (18) individuals with a maximum length of stay of thirty (30) service days. Service in the APH Program may only go beyond thirty (30) service days with written justification provided by the attending physician.

J. The provider must maintain a daily schedule of therapeutic activities to include individual, group, family, and other activities that are designed to provide intensive support to the individuals in the program and reduce acute symptomology.

K. The program must have sufficient space to accommodate the full range of program activities and services and must provide a minimum of fifty (50) square feet of multipurpose space for each individual served.

Rule 23.2 Partial Hospitalization Program for Individuals with Substance Use Disorders

A. Partial Hospitalization Program (PHP) provides direct access to psychiatric, medical and laboratory services to meet the needs that warrant daily monitoring or management but which can be appropriately addressed in a structured outpatient setting. PHP is designed to provide an alternative to inpatient hospitalization for such individuals or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on need

but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms.

B. There must be written policies and procedures implemented for providing PHP that include at a minimum:

5. Admission criteria and procedures. These procedures must require that a physician conduct an admission evaluation and certify that the service is required to reduce or prevent inpatient services.
6. Procedures requiring documented medical supervision and follow along with on-going evaluation of the medical status of the individual.
7. Procedures requiring documented support services for families and significant others.
8. Procedures implementing and documenting discharge criteria to include follow-up planning.

C. The staff for PHP Services must include at each site a full time director who plans, coordinates, and evaluates the program.

D. PHP Services staff must have adequate substance use and addictive disorders experience and meet the following minimum educational requirements:

4. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field experience must be on-site for six (6) or fewer persons for which the program is certified to serve. The staff can be the on-site Program Director if he/she is actively engaged in programmatic activities with individuals during all program hours.
5. At least one (1) staff member with a minimum of a Master's degree in a mental health or related field and at least one (1) staff with a minimum of a Bachelor's degree in a mental health or related field when seven (7) through twelve (12) participants are served.
6. At least one (1) staff with a minimum of a Master's degree in a mental health or related field, at least one (1) staff with a minimum of a Bachelor's degree in a mental health or related field and least one (1) support staff when thirteen (13) through eighteen (18) participants are served in the program.

E. The PHP Program must provide adequate nursing and psychiatric services to all individuals served as needed. At a minimum, Psychiatric services must be offered at admission to the program. Services thereafter must be offered according to the individuals mental health condition.

F. Medical supervision and nursing services must be immediately available and accessible to the program during all hours of operation.

G. The PHP Program can be operated seven (7) days per week, but must at minimum:

5. Operate four (4) days per week.

6. Operate four (4) hours per day, excluding transportation time.
7. Provide at least 20 hours of treatment service per week
8. Be available twelve (12) months per year.

H. The PHP Program must be designed for a maximum number of eighteen (18) individuals with a maximum length of stay of thirty (30) service days. Service in the PHP Program may only go beyond thirty (30) service days with written justification provided by the attending physician.

I. The provider must maintain a daily schedule of therapeutic activities to include individual, group, family, and other activities that are designed to provide intensive support to the individuals in the program.

J. The program must have sufficient space to accommodate the full range of program activities and services and must provide a minimum of fifty (50) square feet of multipurpose space for each individual served.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 24: Day Programs and Employment Related Programs for Adults with SMI

Rule 24.1 Psychosocial Rehabilitation Services

A. Psychosocial Rehabilitative Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the individual in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

B. PSR services/programs must utilize systematic, curriculum based interventions for recovery skills development for participants. The curriculum based interventions must be evidence-based or recognized best practices in the field of mental health as recognized by SAMHSA. Curriculum based interventions must address the following outcomes for the individuals participating in PSR:

7. Increased knowledge about mental illnesses
8. Fewer relapses
9. Fewer re-hospitalizations
10. Reduced distress from symptoms
11. Increased consistent use of medications
12. Increased recovery supports to promote community living

G. The PSR systematic and curriculum based interventions must address the following core components:

3. Psychoeducation
4. Relapse Prevention
3. Coping Skills Training
4. Utilizing Resources and Supports (inclusive of crisis planning)

H. The PSR systematic and curriculum based interventions must, at a minimum, include the following topics:

1. Recovery strategies
2. Facts about mental illnesses
3. Building social supports
4. Using medications effectively
5. Drug and alcohol use
6. Reducing relapse

7. Coping with stress
8. Coping with problems and symptoms of mental illnesses
9. Self-advocacy

I. All individuals are required to have an Individual Recovery Action Plan (IRAP) or Wellness Recovery Action Plan (WRAP). Individuals must participate in setting goals and assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths, knowledge and needs in the individual's living, learning, social, and working environments.

J. Each individual must be provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated recovery goals.

K. ~~For PSR programs that select to utilize the Individual Recovery Action Plan, the IRAP must address the following components :~~

~~1. Problem(s) from the Individual Service Plan that is the focus of PSR Services~~
~~2. Goal(s) from the Individual Service Plan that is the focus of PSR Services~~
~~3. The individual's definition of quality of life~~
~~4. Outcomes the individual desires~~
~~5. Identification and integration of natural supports to connect to community~~
~~6. Utilization of formal and informal resources to support goals and desired outcome.~~

M. Documentation of therapeutic activities must be provided in weekly progress notes.

N. Individuals participating in PSR services may participate in the service up to five (5) hours per day up to five (5) days per week.

O. PSR services must have sufficient space to accommodate the full range of therapeutic activities and must provide at least fifty (50) square feet of space for each individual.

P. PSR services must be located in their own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other services/programs during hours of program operation.

Q. The PSR program must include, at each site, a full time supervisor (see qualifications, Rule 11.3). A Director or Mental Health Therapist (see qualifications section) with the responsibility of therapeutic oversight must be on site a minimum of five (5) hours per week. The Program Director or Mental Health Therapist must plan, develop and oversee the use of <u>an Evidenced Based</u> ~~systematic curriculum based interventions~~ implemented to address the needs of the individuals receiving PSR services. <u>The chosen Evidence Based Curriculum must be implemented to fidelity.</u> In addition to the minimum of five hours of on-site supervision, the Director or Mental Health Therapist must also participate in clinical staffing and/or Treatment Plan review for the individuals in the program(s) that he/she directs.

R. PSR services must maintain a minimum of one (1) qualified staff member to each twelve (12) or fewer individuals present in a PSR program. The supervisor may be included in this ratio.

N. ~~The PSR Therapist supervising the program or PSR Supervisor must complete an evaluation of fidelity to ensure requirements for any evidence-based curriculum utilized by the program are being implemented as designed. All completed fidelity scales must be kept at each site for review.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.2 Senior Psychosocial Rehabilitation Services

N. Senior Psychosocial Rehabilitation Services (Senior PSR) are structured activities designed to support and enhance the ability of the elderly to function at the highest possible level of independence in the most integrated setting appropriate to their needs. The activities target the specific needs and concerns of the elderly, while aiming to improve reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Activities in the program are designed to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

B. Senior PSR must be designed to serve elderly persons with serious mental illness who need assistance in socialization, training for daily living skills, use of leisure time activities, or other structured assistance in activities of life.

~~C. Plans to involve the individuals participating in Senior PSR to the maximum extent possible in community activities must be implemented.~~

C. ~~D.~~ No individuals under fifty (50) years of age can be considered for Senior PSR. All individuals in the program must voluntarily submit an application for the program, which must be maintained at each site in addition to his/her case record.

D. ~~E.~~ Senior PSR programs must have an average daily attendance at least five (5) individuals.

~~F. For programs located in a CMHC, the service must be provided in each location a minimum of three (3) days per week for a minimum of four (4) hours per day, excluding travel time.~~

~~G. For programs located in a nursing home, the service must be provided in each location a minimum of three (3) days per week for a minimum of two (2) hours per day, excluding travel time.~~

E. ~~H.~~ Each Senior PSR program must have a written schedule of daily activities on file, which must include group therapy, socialization activities, activities of daily living, and recreational activities.

F. ~~I.~~ Senior PSR must have activities and physical surroundings that are age appropriate.

G. ~~J.~~ The program must have sufficient space to accommodate the full range of program activities and services and must provide at least fifty (50) square feet of usable space for each individual.

H. ~~K.~~ Staff must be assigned full time to Senior PSR.

I. ~~L.~~ There must be a full time supervisor at each site (see qualifications, Rule 11.3). A Director or Mental Health Therapist (see qualifications section) with the responsibility of therapeutic oversight must be on site a minimum of five (5) hours per week. The Program Director (see qualifications, Rule 11.3) or Mental Health Therapist must plan, develop and oversee the use of systematic curriculum based interventions implemented to address the needs of the individuals receiving PSR services. In addition to the minimum of five hours of on-site supervision, the director or Mental Health Therapist must also participate in clinical staffing and/or Treatment Plan review for the individuals in the program(s) that he/she directs.

J. ~~M.~~ In addition to Rule 24.1.I, Senior PSR located in a Community Mental Health Center operated facility must meet the following:

1. There must be at least one staff member with minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who must be on-site and be actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor.
2. The staff person with a Bachelor's (who must be on-site and actively engaged in program activities during all programmatic hours and who may or may not be the on-site supervisor) is required for eight (8) or fewer people.
3. When the program is certified for nine (9) or more people, there must be another staff person for every eight (8) individuals.
4. Develop and implement plans to involve the individuals participating in Senior PSR in community activities to the maximum extent possible.
5. SPSR services must be provided in each location a minimum of three (3) days per week for a minimum of four (4) hours per day, excluding travel time.

K. ~~N.~~ In addition to Rule 24.1.I, Senior PSR located in a Licensed ~~n~~Nursing ~~home~~ facility must meet the following:

1. There must be at least one staff member with minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who must be on-site and be actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor.

2. The staff person with a Bachelor's (who must be on-site and actively engaged in program activities during all programmatic hours and who may or may not be the on-site supervisor) is required for eight (8) or fewer people.
3. When the program is certified for nine (9) or more people, there must be another staff person for every eight (8) individuals for which the program is certified to serve.
4. DMH will accept verification of licensure from the MS State Department of Health as evidence that programs are addressing and meeting requirements for environment and safety.
5. SPSR services must be provided in each location a minimum of three (3) days per week for a minimum of two (2) hours per day, excluding travel time.
6. Individuals receiving Senior PSR services who are also Medicaid beneficiaries must also be authorized through the Preadmission Screening and Resident Review (PASRR) Rules.

~~O. All individuals admitted to Senior PSR that is not located in a nursing facility, must have a medical screening by a licensed physician or certified nurse practitioner, including a statement from the examiner which verifies the individual is free from disease and does not have any health condition that would create a hazard for other individuals or employees of the service. The result of the examination is to be placed in each individual's record. No one will be admitted to or retained in the Senior Psychosocial Rehabilitation program without such required documentation. This screening must be completed within seventy-two (72) hours of admission, but no earlier than thirty (30) days prior to admission.~~

~~P. Individuals receiving Senior PSR services in a nursing home who are also Medicaid beneficiaries must also be authorized through the Preadmission Screening and Resident Review (PASRR) Rules.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.3 Training Requirements for Senior Psychosocial Rehabilitation Services

A. Senior Psychosocial Programs must conduct quarterly staff trainings that address the specialized needs of seniors, to include substance abuse issues. All Senior PSR staff are required to attend. Training must be documented in the staff personnel record with a copy kept at the program location.

~~B. In addition to the general orientation requirements in Rule 12.1, Senior PSR staff must receive training on the program objectives specific to Senior PSR Services and may be given the option of attending training at one of the Senior PSR training sites.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 24.4 Supported Employment Services for SMI

A. Supported Employment Services for SMI are provided to individuals with severe and persistent mental illnesses that have indicated that employment is one of their goals. The activities of Supported Employment help individuals achieve and sustain recovery. The ultimate goal of the supported employment program is to assist individuals with serious mental illness in discovering paths of self-sufficiency and recovery rather than disability and dependence.

B. Supported Employment Services will develop policies and procedures to provide and expand evidence-based supported employment services (such as the Individual Placement and Support (IPS) model), to adults with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association. All adult clients with severe mental disorders are eligible, including dual disorders of substance abuse and mental illness.

C. Supported Employment Services must be voluntary.

D. Supported Employment Services will have no eligibility restrictions such as; job readiness, no substance abuse, no violent behavior, minimal intellectual functioning, or mild symptoms.

Rule 24.5 Staffing Requirements for Supported Employment for SMI

I. Supported Employment Services must be delivered by a full-time Supported Employment Specialist. The Supported Employment Specialist will have at least a Bachelor's degree and will function as a part of a multidisciplinary mental health team.

J. Supported Employment sites must have the organizational capacity to provide at least (1) full-time equivalent (FTE) Supported Employment Specialist dedicated to employment services. The site may choose to have more than one Employment Specialist, but each position must be full-time to employment.

K. The Employment Specialist must be fully integrated into the treatment team. Progress notes must show collaboration among therapist, community support specialist, Doctor, etc.

L. The Employment Specialist will have an individual employment caseload not to exceed 20 individuals for any full-time Supported Employment Specialist.

M. Supported Employment Specialists must only provide employment services.

N. If an agency employs multiple Supported Employment Specialists they must have group supervision weekly to share information and help each other with cases. When necessary

the Supported Employment Specialists can provide services, backup and support to another Specialist's caseload.

O. Supported Employment Services must have a designated supervisor. If the provider has more than ten Supported Employment Specialists, the supervisor must be full-time to the Supported Employment program.

P. The responsibilities of the Supported Employment supervisor must include but are not limited to;

6. Conduct weekly supported employment supervision designed to review client situations and identify new strategies and ideas to help clients in their work lives.
7. Communicate with mental health treatment team leaders to ensure that services are integrated, to problem solve programmatic issues (such as referral process, or transfer of follow-along to mental health workers) and to be a champion for the value of work.
8. Attend a meeting for each mental health treatment team on a quarterly basis.
9. Accompany Supported Employment Specialists, who are new or having difficulty with job development, in the field monthly to improve skills by observing, modeling, and giving feedback on skills, e.g., meeting employers for job development.
10. Review current client outcomes with Employment Specialists at least quarterly and set treatment goals to improve program performance.

Rule 24.6 Supported Employment for SMI Service Requirements

BB. Any individual that determines that employment is a treatment goal must be referred to the Supported Employment Specialist. The provider must develop policies and procedures to design a referral system throughout the agency.

CC. Supported Employment Services must:

1. Be individually tailored for each person to address the preferences and identified goals of each individual.
2. Be mobile and develop relationships with local businesses to establish employment opportunities.
3. Be delivered in an ongoing rather than time-limited basis to aid the process of recovery and ensure permanent employment.

DD. Supported Employment Specialist will conduct job discovery with each individual served and find and maintain competitive work in the community. The Supported Employment Specialist and other members of the treatment team will offer on-going support to the individual to help ensure that employment is maintained.

EE. A vocational assessment and profile will be completed, updated and maintained for each person utilizing the service.

FF. Each program must maintain an active updated Local Employer Inventory for their area which includes;

9. Name
10. Type of business
11. Business mission
12. Hiring practices
13. Workforce aim
14. Location
15. Name of personnel director
16. Notes of interest, etc.

GG. Each Supported Employment Specialist carries out all phases of vocational service, including engagement, assessment, job placement, and follow-up before step down to less intensive employment support from another mental health practitioner.

HH. Supported Employment Specialists serve as members of one or two mental health treatment teams from which of the Employment Specialist's caseload is comprised.

II. Supported Employment Specialist will attend mental health treatment team meetings and participate actively in treatment team meetings with shared decision-making. The Employment Specialist should help the team assess employment possibilities for people who have not been referred to supported employment services.

JJ. The Supported Employment Specialist's office must be in close proximity to (or shared with) their mental health treatment team members.

KK. The Supported Employment Specialist must collaborate with Vocational Rehabilitation counselors on a regular basis for the purpose of discussing shared clients and identifying potential referrals.

LL. The agency's Quality Assurance process includes an explicit internal review of the SE program, or components of the program, at least every 6 months through the use of the Supported Employment Fidelity Scale or until achieving high fidelity, and at least yearly thereafter by the DMH Fidelity Review Team. The agency's QA process uses the results of the fidelity assessment to improve SE implementation and sustainability.

MM. Supported Employment Specialist or other MH practitioner must offer clients assistance in obtaining comprehensive, individualized work incentives planning by a specially trained work incentives planner prior to starting a job. They must also facilitate access to work incentives planning when clients need to make decisions about changes in

work hours and pay. Clients are provided information and assistance about reporting earnings to SSA, housing programs, etc., depending on the person's benefits.

NN. Supported Employment Specialists provide clients with accurate information and assist with evaluating their choices to make an informed decision regarding what is revealed to the employer about having a disability. Employment Specialists discuss specific information to be disclosed (e.g., disclose receiving mental health treatment or presence of a psychiatric disability, or difficulty with anxiety, or unemployed for a period of time, etc.) and offers examples of what could be said to employers. Employment Specialists discuss disclosure on more than one occasion (e.g., if clients have not found employment after two months or if clients report difficulties on the job.)

OO. Supported Employment Specialist must complete an initial vocational assessment, which can occur over 2-3 sessions and information is documented on a vocational profile form which includes preferences, experiences, skills, current adjustment, strengths, personal contacts, etc. The vocational profile form is used to identify job types and work environments. The vocational profile form is updated with each new job experience. The assessment aims at problem solving using environmental assessments and consideration of reasonable accommodations. Sources of information include the client, treatment team, clinical records, and with the client's permission, family members and previous employers. Employment Specialists help clients learn from each job experiences and also works with the treatment team to analyze job loss, job problems and job successes.

PP. The initial employment assessment and first face to face employer contact must occur within one month after services begin.

QQ. Employer contacts are based on clients' job preferences (relating to what they enjoy and their personal goals) and needs (including experience, ability, symptomatology, and health, etc., and how they affect a good job and setting match) rather than the job market (i.e., what jobs are readily available).

RR. Each employment specialist makes at least 6 face to-face employer contacts per week on behalf of the clients desiring employment. An employer contact is counted even when an employment specialist meets the same employer more than one time in a week, and when the client is present or not present. Client-specific and generic contacts are included. Employment specialists must use a weekly tracking form to document employer contacts that is reviewed by the SE supervisor on a weekly basis.

SS. Supported Employment Specialists must build relationships with employers through multiple visits in person to learn the needs of the employer, convey what the SE program offers to the employer, and describe client strengths that are a good match for the employer.

TT. Supported Employment Specialists must assist clients in obtaining different types of jobs. Employment specialists provide job options that are and are in different settings

UU. Supported Employment Specialists must assist clients in obtaining jobs with different employers.

VV. Supported Employment Specialists must provide competitive job options that have permanent status rather than temporary or time-limited status, (e.g., TEPs). Competitive jobs pay at least minimum wage and are jobs that anyone can apply for and are not set aside for people with disabilities. (Seasonal jobs and jobs from temporary agencies that other community members use are counted as competitive jobs.)

WW. Clients must receive different types of support that are based on the job, client preferences, work history, needs, etc. These supports are individualized and ongoing. Employment specialist also provides employer support (e.g., educational information, job accommodations) at client's request. The employment specialist helps people move on to more preferable jobs and also helps people with school or certified training programs.

XX. Supported Employment Specialist must have face-to-face contact with client within 1 week before starting a job, within 3 days after starting a job, weekly for the first month, and at least monthly for a year or more, as desired by the clients. Clients will be transitioned to step down job supports from a mental health worker following steady employment.

YY. Vocational services such as engagement, job finding and follow-along supports are provided in natural community settings. Supported Employment Specialist must spend 70% or more time in community.

ZZ. Assertive engagement and outreach must be implemented by integrated treatment team. There must be evidence that all 6 strategies for engagement and outreach are used:

1. Service termination is not based on missed appointments or fixed time limits.
2. Systematic documentation of outreach attempts.
3. Engagement and outreach attempts made by integrated team members.
4. Multiple home/community visits.
5. Coordinated visits by employment specialist with integrated team member.
6. Connect with family, when applicable.

AA. Programs should organize and utilize Community Business Advisory Board as part of their community engagement and outreach efforts. At least one member of the provider's executive team must actively participate on the Board. Meetings must occur at least every six months for high fidelity programs and at least quarterly for programs that have not yet achieved high fidelity.

BB. Programs should adhere to Data and Record Keeping Requirements for Good IPS Fidelity (according to guidelines).

~~Part 2: Chapter 25: Day Programs for Individuals with SMI~~

~~Rule 25.1 Day Support Services~~

~~A. Day Support Services must provide structured, varied and age appropriate clinical activities in a group setting that are designed to support and enhance the individual's independence in the community through the provision of structured supports. Clinical program activities must aim to improve social adaptation, physical coordination, daily living skills, time and resource management, and task completion.~~

~~B. Day Support Services must include, at a minimum;~~

~~1. Group therapy~~
~~2. Individual therapy~~
~~3. Leisure-time activities training~~
~~4. Daily social skills training~~
~~5. Coping skills training~~

~~C. The program must operate with a minimum of five (5) individuals per day for a minimum of two (2) hours per day (excluding travel time), two (2) days per week and have flexible hours (e.g., afternoon and evenings). Planned activities must be available whenever the program is in operation.~~

~~D. During hours of operation, the program is to be located in its own physical space, separate from and not shared with other mental health center activities or institutional settings and impermeable to use by other programs or services with the exception of common kitchen/dining area and restrooms.~~

~~E. The program must have sufficient space to accommodate a full range of service activities and must provide a minimum of fifty (50) square feet of usable space for each participant in all service activities including meals. Additional square footage may be required for people who use wheelchairs.~~

~~F. Written policies and procedures, including a description of the program, must be maintained and must include, but not be limited to, the following:~~

~~1. The purpose, goals, and objectives of the program~~
~~2. Description of the population(s) to be served, including admission criteria, which indicates that individuals served by the program are not appropriate for the more intensive services offered through Psychosocial Rehabilitation Services, but still need structured daily activities~~
~~3. The daily hours of operation and number of people to be served at each program site~~
~~4. Description of the daily activities to be available.~~

M. Day Support Services must include a program supervisor (see Rule 11.3). A Program Director or Mental Health Therapist (see Rule 11.3) with the responsibility of therapeutic oversight must be on site a minimum of five (5) hours per week. The Program Director or Mental Health Therapist must plan, develop and oversee the activities of the program and must also participate in clinical staffing and/or Treatment Plan review for the individuals in the program(s) that he/she implements or directs.

N. Day Support Services must maintain a minimum of one (1) qualified staff member to each twelve (12) or fewer individuals present in a program. The program supervisor may be included in this ratio.

O. Prior authorization for Day Support from the Division of Medicaid, or its designee, must be obtained for individuals receiving Day Support services who are also Medicaid beneficiaries. Individuals receiving Day Support services who are not Medicaid beneficiaries must complete an assessment as outlined in Rule 16.9,A to ensure services are medically/therapeutically necessary.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 25.2 Drop-In Centers

A. Drop-In Centers are programs of structured activities designed to support and enhance the role functioning of individuals who are homeless and individuals who are able to live fairly independently in the community through the regular provision of structured therapeutic support. Program activities aim to improve reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, and task completion as well as to alleviate such psychiatric symptoms as confusion, anxiety, isolation, withdrawal and feelings of low self-worth. Programs also provide basic needs such as food and clothing and link participants with social support services. The activities provided must include, at a minimum, the following: group therapy, individual therapy, social skills training, coping skills training, and training in the use of leisure-time activities.

B. The program must operate a minimum of five (5) hours per day (excluding travel time), three (3) days per week, and have flexible hours (e.g., afternoon and evenings). Planned activities must be available whenever the center is in operation.

C. The program is to be located in its own physical space. During the hours of program operation, the space must be separate from and not shared with other mental health center activities or institutional settings and impermeable to use by other programs or services.

D. The program must have an annual average daily attendance of eight (8) individuals.

E. All program space must be accessible to both individuals and staff. There are to be no "staff-only" or "individual/member-only" spaces.

~~F. The program must have sufficient space to accommodate a full range of service activities and must provide a minimum of fifty (50) square feet of usable space for each participant in all service activities including meals.~~

~~G. Written policies and procedures, including a description of the program, must be maintained and must include, but not be limited to, the following:~~

1. ~~The purpose, goals, and objectives of the program;~~
2. ~~Description of the population(s) to be served, including admission criteria, which indicate that individuals served by the program do not require the more intensive services offered in an Acute Partial Hospitalization Program, Psychosocial Rehabilitation Program, or a Work Activity Center, but still need structured daily activities;~~
3. ~~The daily hours of operation and number of people to be served at each program site;~~
4. ~~Description of the daily activities to be available;~~
5. ~~Description of how to involve family members and significant others in supporting program participants;~~
6. ~~Description of how the Drop In Center interacts with the traditional mental health center/programs;~~
7. ~~Mechanisms to be used to establish members as decision makers in the operation of the service;~~
8. ~~Description of how to develop and maintain consumer volunteers and employ consumers of mental health services; and~~
9. ~~Description of homeless outreach activities.~~

~~H. The structured activities of the program must be designed to:~~

1. ~~Maintain individuals in an environment less restrictive than inpatient services, or Crisis Stabilization Services provided at a Crisis Stabilization Unit~~
2. ~~Develop daily living, social and other therapeutic skills~~
3. ~~Promote personal growth and enhance the self-image and/or improve or maintain the individual's abilities and skills~~
4. ~~Provide assistance in maintaining and learning new skills that promote independence~~
5. ~~Develop interpersonal relationships that are safe and wanted by the individual to eliminate isolation~~
6. ~~Improve physical and emotional well being~~
7. ~~Promote empowerment and recovery.~~

~~I. The provider must have structured activities that include the following as appropriate for each individual:~~

1. ~~Social skills training~~
2. ~~Group therapy~~
3. ~~Individual therapy~~

~~4. Training on use of leisure time activities~~
~~5. Coping skills training.~~

~~J. The program must provide individuals with opportunities for varied activities, active and passive, and for individuals to make choices about the activities in which they participate. Activities can include, but not be limited to: self-help group meetings, group meals, weekly or monthly socials, consumer speakers' bureaus, computer skills training, employment services, peer support, outreach programs, and guest speakers/workshops.~~

~~K. Staffing ratio must be at least one (1) staff member at all times for every twelve (12) individuals served by the program.~~

~~L. The designated program supervisor (see qualifications, Rule 11.3) must be responsible for planning, coordinating, and evaluating the service provided. This person must also have demonstrated competence, specialized background, education, and experience to manage the operation of the program. Program staff must have specialized training in the provision of services to the population(s) being served including cross training where appropriate. Program staff must have specialized training which addresses the needs of the population being served.~~

~~M. Drop In Center programs must have a board or advisory council that is made up of fifty percent (50%) consumers of mental health services.~~

~~N. The program must maintain an evaluation system which addresses at a minimum:~~

~~1. Total number of members on roll;~~
~~2. Daily attendance;~~
~~3. Annual attendance by subgroups (age, sex, race); and~~
~~4. Reasons for leaving the program (i.e. recidivism vs. progression toward community integration).~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

Part 2: Chapter ~~26~~ 25: Day ~~Programs~~ Services for Individuals with Alzheimer's and Other Dementia

Rule ~~26.1~~ 25.1 Alzheimer's Day ~~Programs~~ Services

N. The key elements of Alzheimer's Day ~~Programs~~ Services are ~~an~~ community based programs designed to meet the needs of adults with physical and psychosocial impairments, including memory loss, through individualized care plans. These structured, nonresidential programs provide a variety of social and related support services in a safe setting. ~~interdisciplinary approach to meeting goals for individuals served in the program and the variety of services offered by the program to meet individuals' needs.~~ Alzheimer's Day Services include Alzheimer's Day Programs and Alzheimer's Respite Programs. Alzheimer's Day Programs operate up to eight (8) hours per day, five (5) days per week. Alzheimer's Respite Programs operate up to twenty (20) hours per week with operating times to be determined by the provider. Alzheimer's Day ~~Programs~~ Services ~~differ from other types of care for individuals with Alzheimer's disease and related dementia in that their~~ focus ~~is~~ on the strengths and abilities of individuals served by the program and ~~on~~ optimizing the health of the individuals ~~served~~. Alzheimer's Day ~~Programs~~ Services provide a structured environment for individuals with Alzheimer's disease and related dementia; counseling for family members and/or other caregivers; and education and training for individuals providing services to those with Alzheimer's disease and related dementia and also to family members and/or caregivers; and respite. By supporting families and caregivers, Alzheimer's Day ~~Programs~~ Services enable individuals with Alzheimer's disease and other dementia to live in the community.

~~O. Alzheimer's Day Programs are community based group programs designed to meet the needs of adults with physical and psychosocial impairments, including memory loss, through individualized care plans. These structured, nonresidential programs provide a variety of social and related support services in a safe setting. Alzheimer's Day Programs assess the strengths and needs of individuals and families and offer services to build on their strengths.~~

B. ~~C.~~ Alzheimer's Day ~~Programs~~ Services provide services for adults with physical and psychosocial impairments~~,~~ who require supervision, including:

1. Individuals who have few or inadequate support systems.
2. Individuals who require assistance with activities of daily living (ADLs).
3. Individuals with memory loss and other cognitive impairment(s) resulting from Alzheimer's and other dementia that interfere with daily functioning.
4. Individuals who require assistance in overcoming the isolation associated with functional limitations or disabilities.
5. Individuals whose families and/care givers need respite.
6. Individuals who, without intervention, are at risk of premature long-term placement outside the home because of memory loss and/or other cognitive impairment(s).

Rule 25.2 Alzheimer's Day Programs

A. ~~D.~~ Alzheimer's Day Programs must meet the following minimum staffing requirements:

1. A full-time program supervisor with at least a Bachelor's degree in a mental health, intellectual/developmental disabilities, social service or a related field and be under the supervision of an individual with a Master's degree in mental health or intellectual/ developmental disabilities, or a related field ~~one (1) year of supervisory experience in a mental health, social or health service setting or two (2) years of comparable technical and human services training, with demonstrated competence and experience as a manager in a human services setting~~;
2. A full-time Activities Coordinator~~, who can also serve as assistant program supervisor,~~ with a minimum of a high school diploma or equivalent ~~Bachelor's degree in recreational, music or art therapy~~ and at least one (1) year of experience in developing and conducting activities for the population to be served;
3. A full-time program assistant with a minimum of a high school diploma or equivalent and at least one (1) year of experience in working with adults in a health care or social service setting;
4. ~~A Registered Nurse with at least one (1) year of experience with availability on a contractual, full time or part time basis of no less than eight (8) hours per week;~~
5. ~~Secretary/Bookkeeper with a minimum of a high school diploma or equivalent and skills and training to carry out the duties of the position; and~~
4. ~~6.~~ If volunteers are utilized, individuals who volunteer must demonstrate willingness to work with persons with Alzheimer's disease or related dementia, and they must successfully complete program orientation and training. The duties of volunteers must be mutually determined by volunteers and staff. Volunteers' duties, to be performed under the supervision of a staff member, can either supplement staff in established activities or provide additional services for which the volunteer has special talents.

B. In addition to General Orientation, Alzheimer's Day Program staff must attend training specific to address the needs of persons with cognitive impairment including communication techniques, redirection techniques, and activity interventions.

P. ~~E.~~ The ratio of staff to individuals served by the program must be at least one (1) full-time staff member per four (4) individuals served. The program supervisor may be included in the staffing ratio if he/she is on-site and actively engaged in the program.

D. ~~F.~~ The Alzheimer's Day Program must provide a balance of purposeful activities to meet individuals' interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual). Activities may include, but are not limited to:

1. Personal interaction
2. Individualized activities
3. Small and large group activities
4 Intergenerational experiences

5. Outdoor activities, as appropriate
6. Self-care activities
7. Culturally and ethnically relevant celebrations.

E. ~~G.~~ Individuals served by the program should be encouraged to take part in activities, but may choose not to do so or may choose another activity.

F. ~~H.~~ Individuals must be allowed time for rest and relaxation and to attend to personal and health care needs.

G. ~~I.~~ Activity opportunities must be available whenever the center is in operation. Activity opportunities are defined as structured opportunities for socialization and interaction that are available in large group, small group or individual formats. Opportunities for socialization should be individualized to meet the preferences of the participants.

H. ~~J.~~ Creative arts activities must be provided to improve or maintain physical, cognitive, and/or social functioning of individuals served by the program.

I. ~~K.~~ Family education and training must be made available at least monthly to family(ies) and/or caregiver(s) of individuals served by the program. This training must be designed to improve the well-being and functional level of the individuals served and/or families/caregivers. Provision of family education and training must be documented in the case record. A family education log must be kept by the Program Supervisor.

J. ~~L.~~ Opportunities for case staffing (including problem-solving as to how to respond to challenging scenarios involving individuals who receive services) between supervisory and all program staff must be made on a monthly basis or more frequently if determined necessary by the program supervisor.

K. ~~M.~~ The program must provide individualized assistance with and supervision of Activities of Daily Living (ADLs) in a safe and hygienic manner, with recognition of an individual's dignity and right to privacy, and in a manner that encourages individuals' maximum level of independence.

L. ~~N.~~ The program will ensure that each individual receives a minimum of one mid-morning snack, one nutritious noon meal, and one mid-afternoon snack, as well as adequate liquids throughout the day. ~~The program must establish policies and procedures regarding any food services and comply with regulations established by the Mississippi State Department of Health and maintain documentation of compliance on site.~~

M. ~~O.~~ Each Alzheimer's Day Program location must adhere to the following:

9. Must have its own separate, identifiable space for all activities conducted during operational hours. The Alzheimer's Day Program must provide at least fifty (50) square feet of program space for multipurpose use for individuals served in the program.
10. A single program may serve no more than ~~twenty-five (25)~~ twenty (20) individuals at a time.
11. The facility must be flexible and adaptable to accommodate variations of activities (group and/individual) and services and to protect the privacy of individuals receiving services.
12. Identified space for individuals and/or family/caregivers to have private discussions with staff must be available.
13. Restrooms must be located as near the activity area(s) as possible.
14. A rest area for individuals served in the program must be available. That area must have a minimum of one (1) reclining chair per six (6) individuals served in the program.
15. An operable electronic security system that has the capacity to monitor unauthorized entrance or egress, or other movement through the entrance/exits must be utilized.
16. Outside space that is used for outdoor activities must be safe, accessible to indoor areas, and accessible to individuals with disability(ies).and shall include the following:
    (a) Must have secure, exterior pathway(s), a minimum of four (4) feet in width.
    (b) Adequate outside seating.
    (c) Exterior fencing, a minimum of six (6) feet in height, must enclose the outside area(s) where pathways and seating for individuals served by the program are provided.

Rule 25.3 Alzheimer's Respite Program

A. Alzheimer's Respite Programs must meet the following minimum staffing requirements:

1. A full-time program supervisor with a Bachelor's degree in a mental health, intellectual/developmental disabilities, social service or related field and with at least one (1) year of supervisory experience in a mental health, social or health service setting or two (2) years of comparable technical and human services training, with demonstrated competence and experience as a manager in a human services setting; this person can also serve as the Activities Coordinator;
2. A full-time Activities Coordinator with a minimum of a high school diploma or equivalent and at least one (1) year of experience in developing and conducting activities for the population to be served;
3. A full-time program assistant with a minimum of a high school diploma or equivalent and at least one (1) year of experience in working with adults in a health care or social service setting;
4. If volunteers are utilized, individuals who volunteer must demonstrate willingness to work with persons with Alzheimer's disease or related dementia, and they must

successfully complete program orientation and training. The duties of volunteers must be mutually determined by volunteers and staff. Volunteers' duties, to be performed under the supervision of a staff member, can either supplement staff in established activities or provide additional services for which the volunteer has special talents.

B. In addition to General Orientation, Alzheimer's Day Program staff must attend training specific to address the needs of persons with cognitive impairment including communication techniques, redirection techniques, and activity interventions.

C. The ratio of staff to individuals served by the program must be at least one (1) full-time staff member per four (4) individuals served. The program supervisor may be included in the staffing ratio if he/she is on-site and actively engaged in the program. Volunteers may be included in the staff ratio provided that at least 2 program staff are on-site at the program.

D. The Alzheimer's Respite Program must provide a balance of purposeful activities to meet individuals' interrelated needs and interests (social, intellectual, cultural, economic, emotional, physical, and spiritual). Activities may include, but are not limited to:

1. Personal interaction
2. Individualized activities
3. Small and large group activities
4 Intergenerational experiences
5. Outdoor activities, as appropriate
6. Self-care activities
7. Culturally and ethnically relevant celebrations.

E. Individuals served by the program should be encouraged to take part in activities, but may choose not to do so or may choose another activity.

F. Individuals must be allowed time for rest and relaxation and to attend to personal and health care needs.

G. Activity opportunities must be available whenever the center is in operation. Activity opportunities are defined as structured opportunities for socialization and interaction that are available in large group, small group or individual formats. Opportunities for socialization should be individualized to meet the preferences of the participants.

H. Creative arts activities must be provided to improve or maintain physical, cognitive, and/or social functioning of individuals served by the program.

I. Family education and training must be made available at least monthly to family(ies) and/or caregiver(s) of individuals served by the program. This training must be designed to improve the well-being and functional level of the individuals served and/or

families/caregivers. Provision of family education and training must be documented in the case record. A family education log must be kept by the Program Supervisor.

J. Opportunities for case staffing (including problem-solving as to how to respond to challenging scenarios involving individuals who receive services) between supervisory and all program staff must be made on a monthly basis or more frequently if determined necessary by the program supervisor.

K. The program must provide individualized assistance with and supervision of Activities of Daily Living (ADLs) in a safe and hygienic manner, with recognition of an individual's dignity and right to privacy, and in a manner that encourages individuals' maximum level of independence.

L. The program will ensure that each individual receives a minimum of one snack and one nutritious noon meal, as well as adequate liquids throughout the day for programs that operate four (4) or less hours a day. Programs operating more than four (4) hours a day will ensure each individual receives a minimum of two (2) snacks and one nutritious noon meal, as well as adequate liquids throughout the day.

M. Each Alzheimer's Respite Program location must adhere to the following:

1. Must have its own separate, identifiable space for all activities conducted during operational hours. The Alzheimer's Respite Program must provide at least fifty (50) square feet of program space for multipurpose use for individuals served in the program.
2. A single program may serve no more than twenty (20) individuals at a time.
3. The facility must be flexible and adaptable to accommodate variations of activities (group and/individual) and services and to protect the privacy of individuals receiving services.
4. Identified space for individuals and/or family/caregivers to have private discussions with staff must be available.
5. Restrooms must be located as near the activity area(s) as possible.
6. A rest area for individuals served in the program must be available. That area must have a minimum of one (1) reclining chair per ten (10) individuals served in the program.
7. An operable electronic security system that has the capacity to monitor unauthorized entrance or egress, or other movement through the entrance/exits must be utilized.
8. The use of outside space is encouraged but not required. If a program utilizes outside space, the following guidelines shall be followed:
   (a) Must have secure, exterior pathway(s), a minimum of four (4) feet in width.
   (b) Adequate outside seating.
   (c) Exterior fencing, a minimum of six (6) feet in height, must enclose the outside area(s) where pathways and seating for individuals served by the program are provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter ~~27~~ 26: Day Programs for Children/Youth with SED

Rule ~~27.1~~ 26.1 Day Treatment Services- General

C. Day Treatment Services are the most intensive outpatient services available to children/youth with SED. The services must provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment Services are a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which provides primarily school age children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community. Day Treatment Services are based on behavior management principle and include, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants at a particular site and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

D. At a minimum, one (1) Children's Day Treatment Program must be offered to each school district in the region served by each CMHC.

C. Children/youth must have the following in order to receive Day Treatment Services;

1. An eligibility determination for one of the following: Serious Emotional Disturbance or Autism/Asperger's.
2. A justification of the need for Day Treatment Services which must include documentation of the intensity and duration of problems, as part of the initial assessment or as part of a post-intake case staffing and at least annually thereafter. Documentation must also include the identification of at least three (3) specific behavioral criteria as set forth by DMH whose severity would prevent treatment in a less intensive environment.

D. Children must be between the ages of three – twenty-one (3-21) to be considered for enrollment in Day Treatment Services. Group composition must be both age and developmentally appropriate.

E. Each individual Day Treatment program must operate at a minimum of two (2) hours per day, two (2) days per week up to a maximum of five (5) hours per day, five (5) days per week. Each child/youth enrolled in Day Treatment Services must receive the service a minimum of four (4) hours per week.

F. To ensure each child's confidentiality, no children other than those enrolled in Day Treatment Services can be present in the room during the time Day Treatment Services are being provided.

G. Only one (1) Day Treatment Services program is allowed per room during the same time period.

H. Each individual Day Treatment Services program must operate under a separate DMH Certificate of Operation.

I. The Day Treatment Services Director or their designee (as approved by DMH) must:

3. Supervise, plan, coordinate, and evaluate Day Treatment Services. Supervision must be provided at least one continuous hour per month. This should include participation in clinical staffing and/or Treatment Plan review for the individuals in the program(s) that he/she implements or directs.
4. Provide at least thirty (30) continuous minutes of direct observation to each individual Day Treatment Services program at least quarterly. Documentation of the supervision/observation must be maintained for review.

P. The Day Treatment Specialist must participate in clinical staffing and/or Treatment Plan review for the individuals in the program that he/she serves as the primary clinical staff member.

K. The DMH Division of Certification must be notified immediately of any interruption of service with an individual Day Treatment program extending over thirty (30) days. If operation has been interrupted for sixty (60) calendar days, the DMH Certificate of Operation for that individual program must be returned to the DMH Division of Certification.

L. Day Treatment Services are intended to operate year-round and cannot be designed to operate solely during the summer months.

M. Day Treatment Service programs that are unable to provide services during a school's summer vacation will be allowed to hold that individual program's Certificate of Operation until it can be reopened the following school year. If the program has not reopened within sixty (60) calendar days from the first day of the school year, the Certificate of Operation must be returned to DMH Division of Certification.

N. Individual Day Treatment Service programs that do not meet during summer vacation must offer services (i.e. Community Support Services, outpatient therapy, etc.) for the child/youth to the parent(s)/legal representative(s) for the period Day Treatment Services are temporarily not in operation. Documentation must be maintained in each child/youth's record that availability of other services was explained and offered to the parent(s)/legal representative(s).

O. Individual Day Treatment programs operated in a school must ensure that Day Treatment Services continue to adhere to all DMH Operational Standards for MH/IDD/SUD~~A~~ Community Service Providers for this service. Day Treatment Services are a separate program from educational programs which must meet applicable State Department of Education standards and regulations. Day Treatment Services and educational services may not be provided concurrently.

P. Each Day Treatment program must be designed and conducted as a therapeutic milieu as evidenced by the use of a curriculum approved by the DMH and must include, but not be limited to, such skill areas as functional living skills, socialization or social skills, problem-solving, conflict resolution, self-esteem improvement, anger control and impulse control. The approved curriculum must be kept on site. All activities and strategies implemented must be therapeutic, age appropriate, developmentally appropriate and directly related to the objectives in each child/youth's Individual Service Plan.

Q. All Day Treatment Programs must include the involvement of the family or individuals acting in loco parentis as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

R. Each Day Treatment Program must operate with a minimum of four (4) and a maximum of ten (10) children/youth. A Day Treatment roll/roster cannot exceed ten (10) children/youth per program.

S. Day Treatment Programs developed and designed to serve primarily children/youth with a diagnosis of Autism shall not include more than four (4) children/youth with a diagnosis of Autism.

T. In order to participate in the Day Treatment program, a child or youth must be on the permanent roster for the program. They shall not participate on an intermittent basis.

U. Each Day Treatment Program must have a monthly Master Schedule on file at each location to include, at a minimum, the specific skill areas being addressed each day and the specific times these skill areas are being addressed. Skill area activities shown on the Master Schedule must be curriculum-specific. ~~Identification numbers or letters of individuals receiving services must be listed for all individuals participating in each skill area (time period) being addressed.~~

V. Each Day Treatment Program must comply with the following:

1. A minimum of twenty (20) square feet of usable space per child/youth.
2. In cases of programs located in a school, the mental health provider is responsible for ensuring that the school district provides a site or facility that meets all DMH Health and Safety requirements. Programs that are conducted in space that is currently accredited by the Mississippi Department of Education will be considered as meeting all Environment/Safety standards.
3. Furnishings, equipment, square footage and other aspects of the Day Treatment Program environment must be age-appropriate, developmentally appropriate, and therapeutic in nature.

W. The ratio of staff to children/youth receiving services in each Day Treatment Program will be maintained at a minimum ratio of two on-site persons for a minimum of four (4) up to a maximum of ten (10) children/youth per program. Each program must be led by a

Day Treatment Specialist. Day Treatment Assistants serve as the second needed staff in this ratio.

X. For all children/youth participating in Day Treatment Programs, there must be documentation of plans for transitioning a child to a less intensive therapeutic service. This documentation must be a part of each child's Individual Service Plan and/or case staffing. Transition planning should be initiated when the child begins to receive Day Treatment Services and must be documented within one (1) month of the child's start date for the service.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 27.2 Day Treatment Services for Pre-K

A. In addition to Rule 27.1, the standards that follow pertain to providers of Day Treatment Services that serve children 3-5 years of age who are identified as having a serious emotional disturbance.

B. All children must be signed in and out of the program by a parent/legal representative. If a child is being transported by the program staff, the parent/legal representative must sign when they put the child on and take the child off of the van. The parent/legal representative must sign their full name along with the time. If the child is to be signed in/out by any person other than the parent/legal representative, written permission from the parent/legal representative must be in the child's record. Sign In/Out documentation must be available for review.

C. Chairs and tables used in the room where Day Treatment Services are provided must be appropriate to the size and age of the children. This furniture must be kept clean with frequent disinfection.

D. Individual hooks or compartments must be provided for each child for hanging or storing outer and/or extra clothing. Individual hooks or compartments must be spaced well apart so that clothes do not touch those of another child. Each child must have an extra change of properly sized and season-appropriate clothes stored at the program at all times.

E. All children participating in Day Treatment Services must be age-appropriately immunized and must have a Mississippi State Department of Health Certificate of Immunization Compliance on file.

F. Any child who is suspected of having a contagious condition must be removed from the room where Day Treatment Services are being provided and sent home with their parent/legal representative as soon as possible. The child will not be allowed to return to the Day Treatment program until they have been certified by a physician as no longer being contagious. Conditions that would require exclusion from the program include fever, diarrhea, vomiting, rash, sore throat if accompanied by a fever, and/or eye discharge.

G. During the hours the Day Treatment Program is in operation, children must be offered adequate and nutritious meals and snacks. Menus must be available for review.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter ~~28~~ 27: IDD Day and Employment-Related Programs

Rule ~~28.1~~ 27.1 Day Services – Adult

B. Day Services-Adult is the provision of regularly scheduled, individualized activities in a non-residential setting, separate from the participant's private residence or other residential living arrangements ~~such as assistance and acquisition, retention or improvement in social, self-help, socialization and other adaptive skills that enhance social development and skills in performing activities of daily living.~~ Group and individual participation in activities that include daily living and other skills that enhance community participation and meaningful days for each individual are provided. Personal choice of activities as well as food, community participation, etc. is required and must be documented and maintained in each person's record.

E. Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive ~~social~~ group, individual ~~behavior~~ and interpersonal skills, ~~competence~~, greater independence and personal choice. Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices including what he/she does during the day and with whom they interact.

F. Day Services-Adult must have a community ~~integration~~ component that is individualized and based upon the choices of each person. Community participation activities must be offered to the same degree of access as someone not receiving ID/DD Waiver services. ~~meets each individual's needs for community integration and participation activities.~~ Community integration can be provided individually or in groups of up to three (3) people.

G. Community integration opportunities must be offered to each individual at least weekly and address at least one of the following:

3. Activities which address daily living skills~~/needs~~
4. Activities which address leisure/social/other community activities and events.

~~H. All community integration activities must be based on choices/requests of the individuals served. Documentation of the choices offered and the chosen activities must be maintained in each person's record on the designated form.~~

F. ~~F.~~ Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.

~~G. G. Individuals must be offered choices of activities and allowed to make their own decision in which activities they want to participate.~~

W. ~~H.~~ Transportation must be provided to and from the program and for community ~~outings~~ participation activities.

X. ~~I.~~ Day Services-Adult includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day.

Y. ~~J.~~ A private changing/dressing area must be provided to ensure the dignity of each individual.

Z. ~~K.~~ All supplies and equipment must be appropriate for adults, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired.

AA. ~~L.~~ The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events, both at the certified site and in the community.

BB. ~~M.~~ Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports.

CC. ~~N.~~ Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.

DD. ~~O.~~ The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be offered choices about what they eat and drink.

EE. ~~P.~~ Each individual must have an ~~Individual~~ Activity Support Plan that is developed based on his/her Plan of Services and Supports.

FF. ~~Q. Participants~~ Individuals receiving Day Services-Adult may also receive Prevocational, Supported Employment, or Job Discovery services but not at the same time of the day.

GG. ~~R.~~ The program must be in operation at least five (5) days per week, six (6) hours per day. The number hours of service is based ~~provision must be based~~ on the individual's approved Plan of Services and Supports.

HH. ~~S.~~ There must be a minimum of fifty (50) square feet of usable space per every person in the program. Additional square footage may be required based on the needs of an individual.

II. Day Services-Adult must be distinct from Prevocational Services activities. Community participation activities cannot be comprised of individuals receiving Day Services-Adult with those receiving Prevocational Services. Day Habilitation and Day Services adult can be provided in the same area of a building and community participation activities can be conducted jointly.

JJ. ~~T. For every eight (8) individuals served, there must be at least two (2) staff actively engaged in program activities during all programmatic hours. One (1) of these staff may be the on-site supervisor. Additional staff may be required depending on the needs of the individuals served.~~ Staffing ratios are based upon each person's Inventory for Client and Agency Planning (ICAP) score.

U. Individuals must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

V. Day Services-Adult does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

W. The program must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving ID/DD Waiver services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule ~~28.2~~ 27.2 Community Respite

C. Community Respite is provided in a DMH certified community setting that is not a private residence and is designed to provide caregivers an avenue of receiving respite while the individual is in a setting other than his/her home.

D. Community Respite is designed to provide caregivers a break from constant care giving and provide the individual with a place to go which has scheduled activities to address individual preferences/requirements. ~~and also provides for the health, socialization needs, and community integration of the individual.~~

~~E. Community Respite services are generally provided in the afternoon, early evening and on weekends.~~

P. ~~D.~~ The Community Respite provider must assist the individual with toileting and other hygiene needs.

Q. ~~E.~~ Individuals must be offered and provided choices about snacks and drinks. There must be meals available if Community Respite is provided during a normal mealtime such as breakfast, lunch or dinner.

R. ~~F.~~ For every eight (8) individuals served, there must be at least two (2) staff actively engaged in program activities. One of these staff may be the on-site supervisor.

S. ~~G.~~ Individuals receiving Community Respite cannot be left unattended at any time.

T. ~~H.~~ Community Respite cannot be provided overnight.

U. ~~I.~~ Community Respite is not used in place of regularly scheduled day activities such as Supported Employment, Day Services-Adult, Prevocational Services, or services provided through the school system.

V. ~~J.~~ Individuals who receive Host Home Services, Supervised Living, Shared Supported Living or ~~and~~ Supported Living cannot receive Community Respite.

W. All supplies and equipment must be age appropriate, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired.

X. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events.

Y. Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports.

Z. Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.

AA. Adults and children cannot be served together in the same area of the building. There must be a clear separation of space and staff.

BB. The program must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving Home and Community Based Services (HCBS) services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule ~~28.3~~ 27.3 Prevocational Services

D. Prevocational Services provide the meaningful day activities of learning and work experiences, including volunteer work, where the individual can develop general, non-job task specific strengths and skills that contribute to paid employment in integrated community settings.

E. Prevocational Services are expected to be provided over a defined period of time with specific outcomes to be achieved as determined by the individual and his/her team.

F. Individuals receiving Prevocational Services must have employment related ~~goals~~ outcomes in their Plan of Services and Supports; the general habilitation activities must be designed to support such employment outcomes ~~goals~~.

G. ~~Competitive integrated employment in the community for which an individual is compensated at or above the minimum wage, but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities, is considered to be the optimal outcome of Prevocational Services.~~

Y. ~~E.~~ Prevocational Services ~~should~~ must enable each individual to attain the highest level of work in an integrated setting with the job matched to the individual's interests, strengths, priorities, abilities, and capabilities, while following applicable federal wage guidelines.

Z. ~~F.~~ Services are intended to develop and teach general skills that are associated with building skills necessary to perform work optimally in competitive, integrated employment. Teaching job specific skills is not the intent of Prevocational Services. Examples include but are not limited to:

1. Ability to communicate effectively with supervisors, coworkers and customers
2. Generally accepted community workplace conduct and dress
3. Ability to follow directions; ability to attend to tasks
4. Workplace problem solving skills and strategies
5. General workplace safety and mobility training
6. Attention span
7. Motor skills
8. Interpersonal relations

AA. ~~G.~~ Participation in Prevocational Services is not a prerequisite for Supported Employment. An individual receiving Prevocational Services may pursue employment opportunities at any time to enter the general work force.

BB. ~~H.~~ Prevocational Services may be furnished in a variety of locations in the community and are not limited to fixed program locations.

CC. ~~I.~~ Community job exploration activities must be offered to each individual at least one time per month and be provided individually or in groups of up to three (3) people. Documentation of the choice to participate must be documented in each individual's record. Individuals who require one-on-one assistance must be included in community job exploration activities. Community participation activities must be offered to the same degree of access as someone not receiving services.

DD. ~~Individuals may be compensated in accordance with applicable Federal Laws.~~

I. ~~K.~~ Transportation must be provided to and from the program and for community integration/job exploration.

J. ~~L.~~ Any individual receiving Prevocational Services who is performing productive work as a trial work experience that benefits the organization or that would have to be performed by someone else if not performed by the individual must be paid commensurate with members of the general work force doing similar work per wage and hour regulations of the U.S. Department of Labor. Services must be time limited with a written plan. The plan must include job exploration, work assessment, and work training. The plan must also include a statement of needed services and the duration of work activities.

K. ~~M.~~ At least annually, providers will conduct an orientation informing individuals about

Supported Employment and other competitive employment opportunities in the community. This documentation must be maintained on site. Representative(s) from the Mississippi Department of Rehabilitation Services must be invited to participate in the orientation.

L. ~~N.~~ Personal care assistance from staff must be a component of Prevocational Services. Individuals cannot be denied Prevocational Services because they require assistance from staff with toileting and/or personal hygiene.

M. ~~O.~~ Mobile crews, enclaves and entrepreneurial models that do not meet the definition of Supported Employment and that are provided in groups of up to three (3) people can be included in Prevocational Services away from the program site and ~~as trial work experiences. Trial work experiences must~~ be documented as part of the individual plan.

~~P. For every sixteen (16) individuals served, there must be at least two (2) staff actively engaged in program activities during all programmatic hours. One of these staff may be the on-site supervisor.~~

N. ~~Q.~~ There must be a minimum of fifty (50) square feet of usable space per individual receiving services in the service area. Additional square footage may be required based on the needs of an individual.

O. ~~R.~~ The program must be in operation a minimum of five (5) days per week, six (6) hours per day. ~~Service provision must be~~ The number hours of service is based on an individual's approved Plan of Services and Supports.

P. ~~S.~~ The program must ensure it will make available lunch and/or snacks for individuals who do not bring their own.

Q. ~~T.~~ Individuals receiving Prevocational Services may also receive Day Services-Adult, or Job Discovery and/or Supported Employment, but not at the same time of day.

R. ~~U.~~ Individuals must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

S. ~~V.~~ Documentation is maintained that the service is not otherwise available under a program funded under the Section 110 Rehabilitation Act of 1973 or the IDEA (20 U.S.C. 1401 et seq).

~~W. All certified providers of Prevocational Services must have and implement a "Return to Services" policy which ensures individuals who leave Prevocational Services to work in the community can return to needed services if his/her community job ends.~~

T. Prevocational Services activities must distinct from other service activities. Additionally, community participation activities cannot be comprised of individuals receiving Prevocational Services and individuals receiving another service.

U. Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices, including but not limited to daily activities, physical environment and with whom they interact.

V. A private changing/dressing area must be provided to ensure the dignity of each individual.

W. Individuals aging out of school services must be referred to the Mississippi Department of Rehabilitation Services and exhaust those Supported Employment benefits before being able to enroll in Prevocational Services.

X. The amount of staff supervision someone receives is based on tiered levels of support determined by a person's score on the Inventory for Client and Agency Planning (ICAP).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule ~~28.4~~ 27.4 Job Discovery

I. Job Discovery includes, but is not limited to, the following types of person-centered services:
   10. Face-to-face interviews that include a review of current and previous supports and services
   11. Assisting the individual with volunteerism, self-determination and self-advocacy
   12. Identifying ~~wants and~~ support needs ~~for supports~~
   13. Developing a plan for achieving integrated employment
   14. Job exploration
   15. Job shadowing
   16. Internships
   17. Employment (informational) ~~interviewing~~ seeking skills; current labor market
   18. Interviewing skills
   19. ~~Labor market research~~
   15. Job and task analysis activities
   16. Job negotiation
   17. Employment preparation (i.e. resume development, work procedures, soft skills)
   18. Business plan development for self-employment.
   19. Environmental and work culture assessments

J. Job Discovery must include:

   12. Facilitation of a meeting held prior to discovery with the individual and family/friends as appropriate, which describes the job discovery process and its ultimate outcome of securing a community job for the ~~individual~~ job seeker.

13. Visit(s) to the individual's home (if invited; if not, another location) for the purposes of gaining information about routines, hobbies, family supports, activities and other areas related to a person's living situation.
14. Observation of the neighborhood/areas/local community near the individual's home to determine nearby employment, services, transportation, sidewalks and other safety concerns.
15. Interviews with two (2) to three (3) persons, both paid and not paid to deliver services, who know the individual well and are generally active in his/her life.
16. Observations of the individual as he/she participates in typical life activities outside of their home. At least one (1) observation is required.
17. Participation with the individual as he/she participates in typical life activities outside the home. At least two (2) activities are required.
18. Participation in a familiar activity in which the individual is at ~~her~~his/her best and most competent. At least one (1) activity is required.
19. Participation in a new activity in which the individual is interested in participating but has never had the opportunity to do so. At least one (1) activity is required.
20. Review of existing records and documents.
21. Development of discovery notes, Discovery Logs, and photos along with collecting other information that will be useful in development of the individual's Discovery Profile.
22. Development of the Discovery Profile document.

K. Job Discovery is intended to be time-limited; it cannot exceed twenty (20) hours of service over a three (3) month period.

L. The Development of the Discovery Profile results in a person centered, strength based profile and the development of an Employment/Career Plan. ~~The initial discovery process results in the development of a person-centered career profile and employment goal or career plan.~~

M. Individual staff must receive or participate in Customized Employment training as specified by DMH before providing Job Discovery services.

N. Individuals who are currently employed or who receiving Supported Employment Services ~~may not~~ cannot receive Job Discovery services.

~~O. Individuals must be at least 18 years of age to participate in Job Discovery.~~

G. ~~H.~~ An Individual cannot receive Prevocational Services or Day Services-Adult at the same time of day as Job Discovery.

H. Persons eligible for Job Discovery include:

8. Someone who is an adult (age 21) and has never worked.
9. Someone who has previously had two (2) or more unsuccessful employment placements.

10. Someone who is leaving a nursing facility or ICF/IID.
11. Someone who has been in a Prevocational or Work Activity Program and has never had community employment.
12. Someone with multiple disabilities who has previously or never been successful in obtaining community employment.
13. Someone who cannot represent him/herself without assistance and who has previously or never been successful in obtaining community employment.
14. Someone at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule ~~28.5~~ 27.5 Supported Employment for IDD

Q. Before a person can receive Supported Employment services, he/she must first be referred by his/her Support Coordinator to the Department of Rehabilitation Services to determine his/her eligibility for services from that agency. Documentation must be maintained in the record of each individual receiving Supported Employment Services that verifies the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

R. ~~A.~~ Supported Employment is the ongoing support to individuals who, because of their disabilities, will need intensive, ongoing support to obtain and maintain an individual job in competitive ~~or customized employment,~~ or self-employment.

S. ~~B.~~ Employment ~~should~~ must be in an integrated work setting in the general workforce for which an individual is compensated at or above the minimum wage but not less than the customary wage and level of benefits paid by the employer for the same or similar work performed by individuals without disabilities.

T. ~~C.~~ Providers must work to reduce the number of hours of staff involvement ~~over the first few weeks of employment,~~ as the ~~supported~~ employee becomes more productive and less dependent on paid supports. This is decided on an individual basis based on the job and task analysis shared with all staff involved as well as the employer, amount of support recommended by the employer, the Department of Rehabilitation Services and the person's team. ~~individual's identified need for support as established in the Plan of Services and Supports.~~

D. ~~Supported Employment includes activities needed to sustain paid work by individuals, including supervision and training.~~

E. ~~When~~ Supported Employment Services are provided in a work site where individuals without disabilities are employed; therefore, payment is made only for adaptations,

supervision, and training required by individuals receiving waiver services as a result of their disabilities, but does not include payment for the supervisory activities rendered as a normal part of the business setting.

F. Other workplace supports may include services not specifically related to job skills training that enable the individual to be successful in integrating into the job setting.

G. Each individual must have an ~~Individual~~ Activity Support Plan that is developed based on his/her Plan of Services and Supports.

H. Providers must be able to provide all activities that constitute Supported Employment ~~including~~:

3. Job Seeking – Activities that assist and individual in determining the best type of job for him/her and then locating a job in the community that meets those stated desires. Job Seeking is limited to ninety (90) hours. Additional hours may be needed if a person needs to find another job. Job seeking includes:

    (a) Completion of IDD Employment Profile
    (b) Person Centered Career Planning which is a discussion of specific strategies that will be helpful to assist job seekers with disabilities to plan for job searches
    (c) Job Development
        (1) What environment does the person enjoy
        (2) In what environments has the person experienced success
        (3) What work and social skills does the person bring to the environment
        (4) What environments are their skills viewed as an asset
        (5) What types of work environments should be avoided
    (d) Employer research
    (e) Employer needs assessment
        (1) Tour the employment site to capture the requirements of the job
        (2) Observe current employees
        (3) Assess the culture and the potential for natural supports
        (4) Determine unmet needs
    (f) Negotiation with prospective employers
        (1) Employer needs are identified
        (2) Job developer acts as a representative for the job seeker

4. Job Coaching – Activities that assist and individual to learn and maintain a job in the community. The amount of Job Coaching a person receives is dependent upon individual need, team recommendations, and employer evaluation. Job coaching includes:

    (a) Meeting and getting to know co-workers and supervisors
    (b) Learning company policies, dress codes, orientation procedures, and company culture
    (c) Job and task analysis

(1) Core work tasks
(2) Episodic work tasks
(3) Job related tasks
(4) Physical demands
(5) Sensory and communication demands
(6) Academic demands

(d) Systematic instruction
(1) Identification and instructional analysis of the goal
(2) Analysis of entry behavior and learner characteristics
(3) Performance Objectives
(4) Instructional strategy

(e) Identification of natural supports
(1) Personal associations and relationships typically developed in the community that enhance the quality and security of life
(2) Focus on natural cues
(3) Establish circles of support

(f) Ongoing support and monitoring

~~1. Assessment~~
~~2. Job development and placement~~
~~3. Job training~~
~~4. Negotiation with prospective employers~~
~~5. Job analysis~~
~~6. Systematic instruction~~
~~7. Ongoing job support and monitoring~~

I. If an individual moves from one job to another or advances within the current employment site, it is the Supported Employment provider's responsibility to update the profile/resume created during the job search ~~Job Discovery (if applicable) and to use the profile in obtaining another job for the individual.~~

J. Transportation will be provided between the individual's place of residence for job seeking as well as between ~~and~~ the site of the individual's job or between habilitation sites as a component part of Supported Employment. Transportation cannot comprise the entirety of the service. If local or other transportation is available, the individual may choose to use it but the provider is ultimately responsible for ensuring the availability of transportation.

K. Supported Employment may also include services and supports that assist the individual in achieving self-employment through the operation of a business, either home-based or community-based. Such assistance may include:

7. ~~Aiding~~ Assisting the individual to identify potential business opportunities
8. Assistance in the development of a business plan, including potential sources of business financing and other assistance in developing and ~~launching~~ starting a business (e.g. internet and telephone service, website development, advertising,

incorporation, taxes, etc.).

9. Identification of the supports that are necessary for the individual to operate the business
10. Ongoing assistance, counseling and guidance once the business has been launched.
11. Up to fifty-two (52) hours per month of at home assistance by a job coach, including business plan development and assistance with tasks related to producing the product
12. Up to thirty-five (35) hours per month for assistance in the community by a job coach.

L. Payment is not made for any expenses associated with starting up or operating a business. Referrals for assistance in obtaining supplies and equipment for someone desiring to achieve self-employment should be ~~made to~~ developed with the Mississippi Department of Rehabilitation Services. There must be documentation of the referral in the person's record.

M. Assistance with toileting and hygiene may be a component part of Supported Employment, but may not comprise the entirety of the service.

N. Individuals cannot receive Supported Employment and Job Discovery. ~~at the same time~~.

O. Supported Employment does not include facility based or other types of services furnished in a specialized facility that are not part of the general workforce. Supported Employment cannot take place in a facility based program.

P. Supported Employment does not include volunteer work, career exploration or internships.

Q. Providers are prohibited from making incentive payments to an employer to encourage or subsidize the employer's participation in the Supported Employment Program and/or passing payments through to users of Supported Employment Services.

U. Individuals receiving Supported Employment may also receive Prevocational Services or Day Services-Adult services, but not at the same time of day.

V. An individual must be at least 18 years of age to participate in Supported Employment and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

~~W. Documentation must be maintained in the record of each individual receiving Supported Employment Services that verifies the service is not available under a program funded under Section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).~~

X. All required staff and/or those chosen by the person, must participate in the development of the Plan of Services and Supports.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

~~Part 2: Chapter 29: IDD Day Programs – Non Waiver~~

Rule ~~29.1~~ 27.6 Work Activity Services

B. Work Activity Services for persons with intellectual disabilities/developmental disabilities provide opportunities for the acquisition of necessary work and living skills. A person must be at least sixteen (16) years old to participate in Work Activity Services. (Accepting individuals younger than eighteen (18) is optional for the provider.)

B. Each program must be certified by the U.S. Department of Labor. The appropriate Department of Labor certificate must be posted in a public area at each Work Activity service site.

C. Work Activity Services must include:

1. Work which is:
   a. Real, remunerative, productive, and satisfying for the individual served; and
   b. Planned and adequate to keep all individuals productively and appropriately occupied.

2. Non-work which:
   a. Is intended to increase and enhance activities which allow the individual to be more self-sufficient and to increase community employment and integration;
   b. Takes place when work is reduced and/or when the individual chooses.

D. The ~~Individual~~ Plan Services and Supports for ~~of~~ all participants in Work Activity Services must include a career development outcome ~~goal~~ that addresses an individual's ~~goals~~ desire for integrated community employment and ~~objectives~~ activities to support the individual in the achievement of that outcome. ~~those goals~~.

E. The program must have adequate work to keep individuals productively occupied while at the center.

F. The program must assure reasonable accommodations in assisting the individual in increasing his/her productivity. Expected accommodations must, as needed, include:

1. Modifying equipment, jigs, and fixtures.
2. Modifying the work site and commonly used surrounding areas.
3. Purchasing aids and devices to assist individuals with their work.
4. Allowing flex time, part-time or extended break time.

G. Wage payments must be monetary and not in-kind or barter. Records pertaining to individual wages must include, at a minimum, the following:

1. Individual's name
2. Hours worked
3. Task(s) performed
4. Wages paid
5. Method of payment (cash, check, direct deposit.).

H. Each person must receive a written statement for each pay period which must include:

6. Gross pay
7. Net pay
8. Hours worked
9. Deductions
10. The individual's signature indicating he/she received a written statement (even if individual has chosen the option of direct deposit). These signatures must be maintained in the individual's record.

I. Pay periods cannot exceed thirty-one (31) calendar days.

J. The program must complete Time Studies and maintain the documentation in order to demonstrate wage payments are based on a system of individual performance rather than pooled and/or group wage payments.

K. Community wage rate information must be obtained annually and must include at a minimum the following:

1. Prevailing wage for the type or similar type of work being performed;
2. Dates community wage rate information was obtained; and
3. Source of the information.

L. Work Activity center staff must meet at least annually with the individuals to discuss matters of mutual concern. The program must maintain minutes for the meeting and ensure at least the following are addressed:

1. Individuals are informed of any aspects of program operations and plans which effect their wages or welfare;
2. Individuals are asked for suggestions for changes/improvements they would like to see; and
3. Individuals are afforded the opportunity to ask questions and receive answers.

M. A minimum of fifty (50) square feet of usable space per individual receiving services must be maintained in the work area. The program must have adequate floor space for a lounge/break/dining area separate from the work area.

N. Preventive measures must be utilized at all times to ensure the safety of the individuals and staff which include, at a minimum:

7. The safe use of equipment.
8. The use of protective clothing, shoes, and eyewear.
9. The proper storage of flammable liquids or other harmful materials in approved containers. If the liquids/harmful materials are not in their original container, it must be clearly marked to identify its contents.
10. The storage and control of raw materials and finished products outside the work area.
11. The replacement of worn electrical cords or machinery; and
12. The maintenance of the site and equipment in a safe manner.

~~O. All certified providers of Work Activity Services must have and implement a "Return to Services" policy which ensures individuals who leave Work Activity Services to work in the community can return to needed services if his/her community job ends.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 27.7 Day Habilitation for IDD Community Support Program

W. Day Habilitation is the provision of regularly scheduled, individualized activities in a non-residential setting, separate from the participant's private residence or other residential living arrangements Group and individual participation in activities that include daily living and other skills that enhance community participation and meaningful days for each individual are provided. Personal choice of activities as well as food, community participation, etc. is required and must be documented on the designated form and be maintained in each person's record.

X. Activities and environments are designed to foster meaningful day activities for the individual to include the acquisition and maintenance of skills, building positive group, individual and interpersonal skills, greater independence and personal choice. Services must optimize, not regiment individual initiative, autonomy and independence in making informed life choices including what he/she does during the day and with whom they interact.

Y. Day Habilitation must have a community component that is individualized and based upon the choices of each person. Community participation activities must be offered to the same degree of access as someone not receiving IDD Community Support Program services. Community integration can be provided individually or in groups of up to three (3) people. Community participation activities may be received at the same time with individuals receiving Day Services Adult but not with individuals receiving any other service.

Z. Community integration opportunities must be offered to each individual at least weekly and address at least one of the following:

3. Activities which address daily living skills
4. Activities which address leisure/social/other community activities and events.

AA. Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities, including those offered on site and in the community.

BB. Transportation is not required to be provided to and from the program but must be provided for community outings.

CC. Day Habilitation includes assistance for individuals who cannot manage their personal toileting and hygiene needs during the day.

DD. A private changing/dressing area must be provided to ensure the dignity of each individual.

EE. All supplies and equipment must be appropriate for adults, in good repair, clean and adequate enough in number to meet all needs and allow participation in activities as desired.

FF. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to participate fully in all program activities and events, both at the certified site and in the community.

GG. Individuals must be assisted in using communication and mobility devices when indicated in the individualized Plan of Services and Supports.

HH. Staff must provide individuals with assistance with eating/drinking as needed and as indicated in each individual's Plan of Services and Supports.

II. The provider is responsible for providing one (1) mid-morning snack, a noon meal and an afternoon snack. Individuals must be offered choices about what they eat and drink.

JJ. Each individual must have an Activity Support Plan that is developed based on his/her Plan of Services and Supports.

KK. Individuals receiving Day Habilitation may also receive Prevocational services but not on the same day. Individuals receiving Day Habilitation may also receive Supported Employment but not at the same time of day.

LL. The program must be in operation at least five (5) days per week, six (6) hours per day. The number of hours of service is based on the individual's approved Plan of Services and Supports and cannot be delivered less than four (4) hours per day one (1) day per week.

MM. There must be a minimum of fifty (50) square feet of usable space per every person in the program. Additional square footage may be required based on the needs of an individual.

NN. Day Habilitation activities must be distinct from Day Services Adult activities.

OO. Staffing ratio for persons in Day Habilitation is one (1) staff for every eight (8) persons. If individuals receiving Day Services-Adult are served alongside individuals receiving Day Habilitation, the staffing ratios for both must be maintained.

PP. Individuals must be at least 18 years of age and have documentation in their record to indicate they have received either a diploma or certificate of completion if they are under the age of 22.

QQ. Day Habilitation does not include services funded under section 110 of the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (20 U.S.C. 1401 et seq.).

RR. The program must be located in the community so as to provide access to the community at large including shopping, eating, parks, etc. to the same degree of access as someone not receiving ID/DD Community Support Program services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 28: Community Living Services for Individuals with SMI

Rule 28.1 Supervised Living for SMI Service Components

L. Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance,

M. Supervised Living Services may be intensive, time-limited for adults with serious mental illness in order to provide readjustment and transitional living services for individuals discharged from a psychiatric hospital who have demonstrated mental, physical, social and emotional competency to function more independently in the community. These time-limited services may also be provided for individuals who need this service as an alternative to a more restrictive treatment setting.

N. Supervised Living Services must include the following services as appropriate to each individual's support needs:

2. Direct personal care assistance activities such as:

(a) Grooming
(b) Eating
(c) Bathing
(d) Dressing
(e) Personal hygiene

2. Instrumental activities of daily living which include:

(o) Assistance with planning and preparing meals
(p) Cleaning
(q) Transportation
(r) Assistance with ambulation and mobility
(s) Supervision of the individual's safety and security
(t) Banking
(u) Shopping
(v) Budgeting
(w) Facilitation of the individual's participation in community activities
(x) Use of natural supports and typical community services available to everyone
(y) Social activities
(z) Participation in leisure activities
(aa) Development of socially valued behaviors
(bb) Assistance with scheduling and attending appointments

3. Methods for assisting individuals arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Documentation of the following must be maintained in each person's record:

   (d) Assistance with making doctor/dentist/optical appointments;
   (e) Transporting and accompanying individuals to such appointments; and
   (f) Conversations with the medical professional, if the individual gives consent.

4. Transporting individuals to and from community activities, other places of the individual's choice (within the provider's approved geographic region), work, and other sites as documented in the individual plan.

5. If Supervised Living staff members have been unable to participate in the development of the individual's plan, staff must be trained regarding the individual's plan prior to beginning work with the individual. This training must be documented.

6. Orientation of the individual to Community Living Services, to include but not limited to:

   (e) Familiarization of the individual with the living arrangement and neighborhood;
   (f) Introduction to support staff and other residents (if appropriate)
   (g) Description of the written materials provided upon admission and
   (h) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.

C. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided throughout the day. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.

   4. Individuals must have access to food at any time, unless prohibited by his/her individual plan.
   5. Individuals must have choices of the food they eat.
   6. Individuals must have choices about when and with whom they eat

D. Individuals receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as part of the Supervised Living program.

E. In living arrangements in which the residents pay rent and/or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:

1. Procedures for setting and collecting fees and/or room and board (in accordance with Part 2: Chapter 10 Fiscal Management)
2. A detailed description of the basic charges agreed upon (e.g. rent (if applicable), utilities, food, etc.)
3. The time period covered by each charge (must be reviewed at least annually or at any time charges change)
4. The service(s) for which special charge(s) are made (e.g., internet, cable, etc.)
5. The written financial agreement must be explained to and reviewed with the individual/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.
6. A requirement that the individual's record contain a copy of the written financial agreement which is signed and dated by the individual/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. A signed copy must also be given to the individual/legal guardian.
7. The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to prevent the individual from becoming homeless as a result of discharge/termination from the community living services.

F. Individuals must be 18 years or older to participate in Supervised Living.

G. A qualified staff member must be designated as responsible for the program site at all times. There must be male/female staff coverage when as necessary.

H. Apartment settings with an apartment manager with responsibilities related to collection of fees, maintenance, etc., must also have at least one treatment/support staff on site in order to be considered Supervised Living.

I. There must be at least one staff person physically on-site when individuals are present.

J. A maximum of eight (8) individuals may reside in a single residence for programs initially certified after the effective date of these standards.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 28.2 Environment and Safety for Supervised Living for SMI

H. Supervised Living sites must, to the maximum extent possible, duplicate a "home-like" environment.

I. All sites must have furnishings that are safe, up-to- date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent possible, are chosen by the individuals currently living in the home.

J. All providers must provide access to a washer and dryer in the home, apartment, or apartment complex and must ensure the laundry room or area has an exterior ventilation system for the clothes dryer.

K. Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

L. Resident bedrooms must not have windows over forty-four inches off the floor if identified as a means of egress. All windows at all levels must be operable.

M. Resident bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

N. Resident bedrooms must be appropriately furnished with a minimum of a single bed, chest of drawers, appropriate lighting and adequate storage/closet space for each resident;

H. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances.

I. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used.

Y. Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

Z. Individuals have the freedom to furnish and decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, etc.

AA. All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

BB. All programs must ensure bathtubs and showers are equipped with:

1. Soap dishes;

2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

CC. Each resident must be provided at least 2 sets of bath linens, including bath towels, hand towels, and wash cloths.

DD. All Supervised Living sites of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system.

EE. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas.

FF. Residential facilities using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas.

GG. Each bedroom must have at least two means of escape.

HH. The exit door(s) nearest the residents' bedrooms must not be locked in a manner that prohibits ease of exit.

II. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom.

JJ. All providers must ensure visiting areas are provided for residents and visitors and each visiting area must have at least two (2) means of escape.

KK. All sites must have separate storage areas for:
4. Sanitary linen;
5. Food (Food supplies cannot be stored on the floor.); and
6. Cleaning supplies.

LL. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

MM. The setting is integrated in and supports full access to the community to the same extent as people not receiving Supervised Living services.

Rule 28.3 Supported Living for SMI Service Components

G. Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support

per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Supported Living services are provided in a homelike setting where people have access to the community at large to the same extent as people who do not have a serious mental illness.

H. Supported Living Services are for individuals age 18 and above with serious mental illness and are provided in residences in the community for six (6) or fewer individuals.

I. Supported Living provides assistance with the following, depending on each individual's support needs:

1. Grooming
2. Eating
3. Bathing
4. Dressing
5. Personal hygiene.

J. Supported Living provides assistance with instrumental activities of daily living which include assistance with:

10. Planning and preparing meals
11. Transportation or assistance with securing transportation
12. Assistance with ambulation and mobility
13. Supervision of the individual's safety and security
14. Banking
15. Shopping
16. Budgeting
17. Facilitation of the individual's inclusion participation in community activities
18. Use of natural supports and typical community services available to all people in order to facilitate meaningful days.

K. Providers must develop methods, procedures and activities to provide meaningful days and independent living choices about activities/services/staff for the individual(s) served in the community.

L. Procedures must be in place for individual(s) to access any other needed services as well as typical community services available to all people in order to facilitate meaningful days and development of natural supports.

Rule 28.4 Supported Living Services for SMI Environment and Safety

G. Each housing unit/house must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the home , (i.e., kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

H. Providers must document that all fire extinguishers are properly maintained and serviced. Homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

I. Each housing unit/house must have, at a minimum, operable carbon monoxide detector where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

J. In lieu of posted escape routes, providers must document training that prepares an individual to exit their housing unit/house in the event of emergency.

K. At least annually, training must be provided to adults individuals receiving Supported Living Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following:

1. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;
2. Fire, smoke and carbon monoxide safety and the use of detectors. If necessary, staff must assist in obtaining and mounting fire, smoke and carbon monoxide detectors;
3. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature, documenting such in a log to be maintained by the provider staff; and,
4. Any other health/safety issues based on the needs or identified risk for each individual.

L. All training for Supported Living must take place upon admission and at least annually thereafter. Documentation is to be maintained in the person's record.

Part 2: Chapter 29: Community Living Services for Children and Youth with SED

Rule 29.1 All Community Living Services for Children/Youth with SED

A. Each child/youth (ages 5 to 16 years) must be enrolled and attend in an appropriate educational program in the local school district or be enrolled in an educational program operated by the provider that meets the individualized educational needs of the child/youth and is accredited by the Mississippi Department of Education. The Community Living Handbook must describe how this occurs for the children/youth served.

B. Providers must provide a balance of age-appropriate, goal-oriented activities to meet the individualized needs and build on the strengths of the children/youth served in the program. Areas to be addressed by such programs must include the following:

1. Social skills development based on each child's diagnosis and functional assessment
2. Wellness education
3. Increasing self-esteem
4. Leisure activities
5. Substance abuse education/counseling
6. HIV/AIDS education and/or counseling
7. Education and counseling about sexually transmitted diseases.

C. Providers must describe how group and individual activities, as well as routines for the children and youth are planned and how these activities are related to objectives in the Individual Service Plans of children and youth served in the program. Daily and weekly schedule(s) of activities must be maintained on file for at least three (3) months.

D. Providers must obtain written permission from the parent or legal representative for the child/youth to participate in program activities away from the Supervised Living location.

E. Providers must ensure child/youth has a dental examination within sixty (60) days after admission and annually thereafter or have evidence of a dental examination within 12 months prior to admission to the Supervised Living program.

F. Providers must place a current, dated photograph of the child in his/her record within thirty (30) days of admission.

G. Providers of services to children/youth under the age of eighteen (18) must have on file an assurance signed by the Executive Director of the Supported Living Service provider stating compliance with the provisions of Public Law 103-227 (Pro-Children Act of

1994). Note: Providers funded by the DMH must have a current "Certification Regarding Environmental Tobacco Smoke."

H. All environmental and physical safety requirements for foster homes and therapeutic group homes are under the jurisdiction of the MS Department of Human Services. DMH is responsible for certifying and monitoring the therapeutic/clinical components of therapeutic foster care services and therapeutic group home services.

Rule 29.2 Therapeutic ~~Treatment~~ Foster Care ~~and Therapeutic Group Homes~~ for Children/Youth with SED

E. Providers of Therapeutic Foster Care (TFC) must also meet the requirements in Rule 29.1.

F. ~~A.~~ Therapeutic ~~Treatment~~ Foster Care (TFC) services are intensive community-based services for children with significant developmental, emotional or behavioral needs provided by mental health professional staff and trained foster parents, resource parents or group home providers who provide a therapeutic program for children and youth with serious emotional disturbances living in a resource home licensed by the Department of Human Services. All environmental and physical safety requirements for therapeutic foster homes are under the jurisdiction of the regulations of the MS Department of Human Services. DMH is not responsible for the licensing or monitoring of therapeutic foster homes. DMH is responsible for the certification of the therapeutic services provided.

G. ~~B.~~ TFC providers can use only adults with current documentation of foster parent or resource family approval from the Mississippi Department of Human Services.

H. ~~C.~~ Each foster home or resource home must have no more than one (1) child/youth with serious emotional disturbance placed in the home at a given time. Providers seeking to place more than one (1) child/youth with serious emotional disturbance in a resource home must obtain prior approval from the Mississippi Department of Human Services. Siblings with serious emotional disturbance may be placed together in the same home if all of the following conditions apply:

4. The siblings have never been separated;
5. The siblings are not a danger to others; and
6. Therapeutic resource parents asked to place siblings in their home must consent, in advance in writing, to the placement. This documentation must be maintained in the individual record of each sibling.

E. ~~D.~~ Each TFC provider licensed for a minimum of ten (10) foster homes or resource homes must have a full-time director with overall administrative and supervisory responsibility for the services.

2. If the TFC provider is certified for fewer than ten (10) homes, the director can have administrative or supervisory responsibility for other services or programs; however, documentation must be maintained that at least fifty percent (50%) of the director's time is spent in administration and supervision of the TFC services.

F. ~~E.~~ Each TFC provider licensed for ten (10) to thirty (30) foster homes or resource homes must have one full-time Treatment Foster Care specialist whose services target the therapeutic foster parents or resource families. The TFC specialist's specific responsibilities must include at least the following:

1. Recruitment and training of therapeutic foster parents or therapeutic resource parents
2. Conducting interviews and other necessary work to appropriately place individual children and youth with prospective therapeutic foster care or resource parents
3. Maintenance of regular contacts with therapeutic foster care or resource families and provide documentation of those contacts in the case records
4. Performance of other foster parent or resource family support activities, as needed.

G. ~~F.~~ If the TFC provider is licensed for fewer than ten (10) foster or resource homes, the TFC specialist can have other responsibilities; however, documentation must be maintained that at least ten percent (10%) of his/her time for every one (1) therapeutic foster home or resource home is spent in performing duties of the TFC specialist/community support specialist.

H. ~~G.~~ The TFC specialist must have face-to-face contact with each therapeutic foster or resource parent(s) at least two (2) times per month, with at least one (1) of the two (2) contacts made during a home visit. All contacts of the TFC specialist with the therapeutic foster or resource parent(s) must be documented in the individual case record of the therapeutic resource parent(s).

I. ~~H.~~ All clinical/mental health therapeutic services for all children receiving TFC services must be provided by a staff member who holds a Master's degree and professional license or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving services and the service being provided).

J. ~~I.~~ TFC Services must include individual therapy, family therapy, ~~TFC support groups for children and TFC families~~, annual psychiatric evaluation, and twenty-four (24) hour per day and seven (7) days a week emergency services and crisis intervention. Group therapy may also be provided.

K. ~~J.~~ Each TFC provider must have one (1) full-time professionally licensed or DMH credentialed mental health therapist for every twenty (20) foster children/youth in the TFC program. The mental health therapist(s) for the TFC services must serve only in the mental health therapist role (i.e. cannot serve as the director or the TFC specialist).

L. ~~K.~~ The mental health therapist is required to have at least one individual therapy session per week with the child/youth. At least one family session per month is required with the resource parent(s).

M. ~~L.~~ A licensed psychiatrist with experience working with children/youth, on an employment or contractual basis, must be available for youth served by the TFC provider.

N. ~~M.~~ All resource parents must complete annual training as required in Part 2: Chapter 12. Topics should be addressed from a family perspective.

Source: Section 41-4-7 of the Mississippi Code, 1972, as amended

Rule 29.3 Therapeutic Group Homes for Children and Youth with SED

~~G. Therapeutic Treatment Foster Care Services may also be provided to children/youth in a Therapeutic Group Home setting.~~

H. Providers of Therapeutic Group Homes (TGH) must also meet the requirements in Rule 29.1.

I. ~~B.~~ The maximum bed capacity of each TGH is ten (10) beds per home for children and youth twelve (12) years of age through age twenty (20) years and (11) eleven months and eight (8) beds for children and youth ages six (6) years through eleven (11) years and eleven (11) months. The Mississippi DMH may require a lower bed capacity than described in this standard, depending on the age, developmental or level of functioning, or intensity of need for intervention and supervision of the population of children and youth served in the individual home.

J. ~~C.~~ There may not be more than two (2) children/youth per bedroom in a Therapeutic Group Home.

E. ~~D.~~ The provider must ensure that the staff on-site is of a sufficient number to provide adequate supervision of child/youth in a safe, therapeutic home environment and must meet the following minimum requirements:

6. In TGH's with five (5) or fewer children or youth, at least one (1) staff member (which can be a direct care worker or house parent) with a least a Bachelor's degree in a mental health or related field must be assigned to direct service responsibilities for the children/youth during all hours.

7. For TGH's with six (6) to ten (10) children or youth, at least two (2) staff must be assigned to direct service responsibilities during all hours children or youth are awake

and not in school. One (1) of the two (2) staff can be a direct care worker or house parent and one must be a professional staff member with at least a Bachelor's degree in a mental health or related field.

8. Have a full-time director who is on-site at least forty (40) hours per week.

9. Other appropriate professional staff must be available to assist in emergencies, at least on an on-call basis, at all times.

10. DMH may require a staff to youth ratio lower than described above, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of children or youth served by the individual home.

F. ~~E.~~ A licensed psychiatrist and a professionally licensed or DMH credentialed mental health therapist with experience working with children/youth must be available for children/youth served by the TGH.

G. ~~F.~~ Programs must provide each child/youth with therapeutic activities and experience in the skills they need to support a successful transition to a less restrictive setting or level of service.

G. ~~Children/youth in the TGH program must receive Treatment Foster Care Services as described above. Documentation must be maintained in the case records of the children/youth indicating the progress/results of the Treatment Foster Care Services.n~~ The mental health therapist is required to have at least one individual therapy session per week with the child/youth.

H. Transition plans must be developed within ninety (90) days prior to completion of a TGH program and be included in the child/youth's record and shared with community service providers.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 29.4 Community Living Handbook

A. In addition to information contained in the provider's policy and procedure manual, Therapeutic Group Home providers must develop a Handbook which includes all policies and procedures for provision of TGH Services. Handbooks are to be provided to the individual/parent/legal representative during orientation. The Community Living Handbook must be readily available for review by staff and must be updated as needed.

B. All providers of TGH Services must document that each individual (and/or parent/guardian) is provided with a handbook and orientation on the day of admission. The provider must document the review of the handbook with the resident annually (if applicable to the service).

C. All TGH providers must have a written plan for soliciting input from residents ~~to be included in~~ about all sections of the handbook.

D. The service and site-specific handbook must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative.

E. TGH providers must have a written plan for providing the handbook information in a resident's language of choice when necessary if English is not their primary language.

F. The Community Living handbook may not be a book of rules.

G. The Handbook may not include any rules or restrictions that infringe on or limit the individual's ability to live in the least restricted environment possible or that limit oc restrict the rights of individuals receiving services specified in Chapter 14 of these standards.

H. At a minimum, the Community Living Handbook must address the following:

1. A person friendly, person first definition and description of the community living service being provided;
2. The philosophy, purpose and overall goals of the service, to include but are not limited to:

   (a) Methods for accomplishing stated goals and objectives
   (b) Expected results/outcomes
   (c) Methods to evaluate expected results/outcomes.

3. Description of the service components, including the minimum levels of staffing required for the safety and guidance of individuals to be served
4. A description of how the TGH service addresses the following items, to include but not limited to:

   (a) Visitation guidelines (applying to family, significant others, friends and other visitors) that are appropriate to TGH services
      (1) Individual's right to define their family and support systems for visitation purposes unless clinically/socially contraindicated
      (2) All actions regarding visitors (restrictions, defining individual and family support systems, etc.) must be documented in the individual's case record
      (3) Any restrictions on visitors must be reviewed whenever there is an identified need or request by the individual to change any of the restrictions
      (4) Visitation rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.
      (5) To the greatest extent possible, individuals should have visitors of their choosing at any time.

(b) Daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated:
   (1) Any restrictions on private telephone use must be reviewed daily
   (2) All actions regarding restrictions on outside communication must be documented in the case record
   (3) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.

(c) Dating
(d) Off-site activities
(e) Household tasks
(f) Curfew
(g) Respecting the rights of other residents' privacy, safety, health and choices.

5. Policy regarding the search of the individual's room, person and/or possessions, to include but not limited to;

   (a) Circumstances in which a search may occur;
   (b) Staff designated to authorize searches;
   (c) Documentation of searches; and
   (d) Consequences of discovery of prohibited items.

6. Policy regarding screening for prohibited/illegal substances, to include but not limited to:

   (g) Circumstances in which screens may occur;
   (h) Staff designated to authorize screening;
   (i) Documentation of screening;
   (j) Consequences of positive screening of prohibited substances;
   (k) Consequences of refusing to submit to a screening; and
   (l) Process for individuals to confidentially report the use of prohibited substances prior to being screened.

9. Orientation of the individual to TGH Services, to include but not limited to:

   (a) Familiarization of the individual with the living arrangement and neighborhood;
   (b) Introduction to support staff and other residents (if appropriate)
   (c) Description of the written materials provided upon admission (i.e., handbook, etc.); and
   (d) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.

10. Methods for assisting individuals in arranging and accessing routine and emergency medical and dental care, to include but not limited to:

(a) Agreements with local physicians and dentists to provide routine care
(b) Agreements with local physicians, hospitals and dentists to provide emergency care
(c) Process for gaining permission from parent/guardian, if necessary.

I. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights;

J. Determination of the need for and development, implementation and supervision of behavior change/management programs;

K. Description of how risks to health and safety of individuals in the program are assessed and the mitigation strategies put in place as a result of assessment; and,

L. Criteria for termination\discharge from the TGH Service.

N. Providers must also address:

1. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared. Individuals must have access to food at any time, unless prohibited by his/her individual plan
2. Personal hygiene care and grooming, including any assistance that might be needed;
3. Medication management (including storing and dispensing); and,
4. Prevention of and protection from infection, including communicable diseases.

O. Providers must develop policies regarding pets and animals on the premises for all TGH programs.

P. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 30: Supervised Living for Individuals with IDD

Rule 30.1 Supervised Living Services for IDD Service Components

C. Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day. Activities must support meaningful days for each person. Activities are to be designed to promote independence yet provide necessary support and assistance,

D. Supervised Living Services must include the following services as appropriate to each individual's support needs:

2. Direct personal care assistance activities such as:

(a) Grooming
(b) Eating
(c) Bathing
(d) Dressing
(e) Personal hygiene

2. Instrumental activities of daily living which include:

(a) Assistance with planning and preparing meals
(b) Cleaning
(c) Transportation
(d) Assistance with ambulation and mobility
(e) Supervision of the individual's safety and security
(f) Banking
(g) Shopping
(h) Budgeting
(i) Facilitation of the individual's participation in community activities
(j) Use of natural supports and typical community services available to everyone
(k) Social activities
(l) Participation in leisure activities
(m) Development of socially valued behaviors
(n) Assistance with scheduling and attending appointments

3. Methods for assisting individuals arranging and accessing routine and emergency medical care and monitoring their health and/or physical condition. Documentation of the following must be maintained in each person's record:

(a) Assistance with making doctor/dentist/optical appointments;

(b) Transporting and accompanying individuals to such appointments; and
(c) Conversations with the medical professional, if the individual gives consent.

4. Transporting individuals to and from community activities, other places of the individual's choice (within the provider's approved geographic region), work, and other sites as documented in the individual plan.

5. If Supervised Living staff members have been unable to participate in the development of the individual's plan, staff must be trained regarding the individual's plan prior to beginning work with the individual. This training must be documented.

6. Orientation of the individual to Community Living Services, to include but not limited to:

(a) Familiarization of the individual with the living arrangement and neighborhood;
(b) Introduction to support staff and other residents (if appropriate)
(c) Description of the written materials provided upon admission and
(d) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.

C. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided throughout the day. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.

4. Individuals must have access to food at any time, unless prohibited by his/her individual plan.
5. Individuals must have choices of the food they eat.
6. Individuals must have choices about when and with whom they eat

D. Individuals receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as part of the Supervised Living program.

E. In living arrangements in which the residents pay rent and/or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:

1. Procedures for setting and collecting fees and/or room and board (in accordance with Part 2: Chapter 10 Fiscal Management)
2. A detailed description of the basic charges agreed upon (e.g. rent (if applicable), utilities, food, etc.)
3. The time period covered by each charge (must be reviewed at least annually or at any time charges change)
4. The service(s) for which special charge(s) are made (e.g., internet, cable, etc.)

5. The written financial agreement must be explained to and reviewed with the individual/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.
6. A requirement that the individual's record contain a copy of the written financial agreement which is signed and dated by the individual/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents. A signed copy must also be given to the individual/legal guardian.
7. The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to prevent the individual from becoming homeless as a result of discharge/termination from the community living services.
8. Individuals receiving ID/DD Waiver services must be afforded the rights outlined in the Landlord/Tenant laws of the State of Mississippi (MS Code Ann. 1972 §89-7-1 to125 and §89-8-1 to 89-8-1 to 89).

P. Individuals must be 18 years or older to participate in Supervised Living.

Q. There must be at least one staff person in the same dwelling as people receiving services at all times that is able to respond immediately to the requests/needs for assistance from the individuals in the dwelling. Staff must be awake at all times.

R. Sites certified after the effective date of the standards, can have no more than four (4) people residing in the home.

S. Individuals have freedom and support to control their own schedules and activities.

3. Individuals cannot be made to attend a day program if they choose to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if they are ill, or otherwise choose to remain at home.
4. Staff must be available to support individual choice.

T. For ID/DD Waiver Supervised Living, there must be a Supervised Living Program Supervisor for a maximum of four (4) Supervised Living locations. The Supervised Living Program Supervisor must meet the qualifications in Standard 11.3.D. Waiver Supervised Living Program Supervisors may be limited to supervise less than 4 homes if deemed necessary by DMH.

1. The Supervised Living Program Supervisor is responsible for providing weekly supervision and monitoring at all four (4) sites.
2. Unannounced visits on all shifts, on a rotating basis must take place monthly.
3. All supervision activities must be documented and available for DMH review. Supervision activities include but are not limited to: review of daily Service Notes to determine if outcomes identified on a person's Plan of Services and Supports are being met; review of meals, meal plans and food availability; review of purchasing;

review of individuals' finances and budgeting; review of each individual's satisfaction with services, staff, environment, etc.

K. Individuals must have control over their personal resources. Providers cannot restrict access to personal resources. Providers must offer informed choice of the consequences/risks of unrestricted access to personal resources. There must be documentation in each person's record regarding all income received and expenses incurred.

L. Nursing services are a component of ID/DD Waiver Supervised Living services and must be provided in accordance with the MS Nursing Practice Act. Nursing services are a component part of ID/DD Waiver Supervised Living. They must be provided on an as-needed basis. Only activities within the scope of the Nurse Practice Act and Regulations can be provided. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring, etc.

Q. Staffing levels are based on the ratios set by a person's score on his/her ICAP.

R. A higher reimbursement rate may be available for individuals enrolled in the ID/DD Waiver who are considered medically fragile and whose medical condition requires intensive supports, including skilled nursing services, that exceed what is required in Rule 30.1.K. Admission must be prior approved by BIDD. Individuals living in the home with someone considered medically fragile must be compatible and not pose a threat to the person who has higher medical support needs.

S. A higher reimbursement rate may be available for individuals enrolled in the ID/DD Waiver who have documented patterns of violent and/or non-violent behavior that pose a risk to themselves or others and who require intensive supports in order to live in the community. This may include one-to-one staff ratios and/or line of sight supervision. Admission must be prior approved by BIDD. Individuals living in the home with someone who requires higher levels of behavior support must be compatible. The person receiving a higher level of support must not pose a threat to others living in the home.

Rule 30.2 Environment and Safety for Supervised Living for IDD

H. Supervised Living sites must, to the maximum extent possible, duplicate a "home-like" environment.

I. All sites must have furnishings that are safe, up-to- date, comfortable, appropriate, and adequate. Furnishings, to the greatest extent possible, are chosen by the individuals currently living in the home.

J. All providers must provide access to a washer and dryer in the home, apartment, or apartment complex and must ensure the laundry room or area has an exterior ventilation system for the clothes dryer.

K. Providers must develop policies regarding pets and animals on the premises. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

L. Resident bedrooms must not have windows over forty-four inches off the floor if identified as a means of egress. All windows at all levels must be operable.

M. Resident bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

N. Resident bedrooms must be appropriately furnished with a minimum of a single bed, chest of drawers, appropriate lighting and adequate storage/closet space for each resident;

H. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances.

I. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used.

AA. Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

BB. Individuals have the freedom to furnish and decorate their own rooms in compliance with any lease restrictions that may be in place regarding wall color, wall hangings, etc.

CC. All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

DD. All programs must ensure bathtubs and showers are equipped with:

1. Soap dishes;
2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

EE. Each resident must be provided at least 2 sets of bath linens, including bath towels, hand towels, and wash cloths.

FF. All Supervised Living sites of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system.

GG. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas.

HH. Residential programs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas.

II. Each bedroom must have at least two means of escape.

JJ. The exit door(s) nearest the residents' bedrooms must not be locked in a manner that prohibits ease of exit.

KK. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom.

LL. All providers must ensure visiting areas are provided for residents and visitors and each visiting area must have at least two (2) means of escape.

MM. All sites must have separate storage areas for:

4. Sanitary linen;
5. Food (Food supplies cannot be stored on the floor.); and
6. Cleaning supplies.

NN. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

OO. The setting is integrated in and supports full access to the community to the same extent as people not receiving Supervised Living services.

PP. There must be visiting hours that are mutually agreed upon by all people living in the residence. Visiting hours cannot be restricted unless mutually agreed upon by all people living in the dwelling.

QQ. Providers must provide furnishings used in common areas (den, dining, and bathrooms) if:

3. The individual does not have these items; or
4. These items are not provided through Bridge to Independence (Money Follows the Person) or Transition Assistance through the ID/DD waiver.

FF. Individuals have choices about housemates and with whom they share a room. There must be documentation in each person's record of the person/people they chose to be their roommate.

GG. Individuals must have keys to their living unit if they so choose.

HH. The setting is selected by the individual from setting options including non-disability specific settings and the option of having a private unit, to the degree allowed by personal finances, in the residential setting. This must be documented in the record.

II. Bedrooms must have lockable entrances with each person having a key to his/her bedroom and only appropriate staff having keys.

JJ. Individuals share bedrooms based on their choices. No more than two individuals may share a bedroom. If a person must share a bedroom, it must be prior approval from BIDD.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 30.3 ID/DD Waiver Host Homes

A. Host Homes must also meet the requirements in Rule 30.1.

B. Host Homes are private homes where no more than one individual who is at least five (5) years of age lives with a family and receives personal care and supportive services. If the person requesting this service is under five (5) years of age, admission must be prior approved by the BIDD Director.

C. Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment.

D. Host Home services include assistance with personal care, leisure activities, social development, family inclusion, community inclusion, and access to medical services.

Natural supports are encouraged and supported. Supports are to be consistent with the participant's skill level, goals, and interests.

E. Host Homes are administered and managed by provider agencies that are responsible for all aspects of Host Home Services. Host Home agencies must:

1. Complete an evaluation of each prospective Host Home family and setting. The evaluation must be prior approved by BIDD;
2. Conduct background checks for all Host Home family members over the age of 18;
3. Provide training to Host Home providers that is in compliance with Chapter 12;
4. Ensure each Host Home family member has had a medical examination within twelve (12) months of anyone moving into the Host Home and at least annually thereafter;
5. Maintain current financial and property records for each individual served in a Host Home;
6. Conduct at least monthly home visits to each Host Home;
7. Ensure availability, quality and continuity of Host Homes;
8. Take into account compatibility with the Host Home Family member(s) including age, support needs, and privacy needs;
9. Ensure each individual receiving Host Home services has his/her own bedroom;
10. Recruit and oversee the Host Home
11. Have 24-hour responsibility for the Host Homes which includes back-up staffing for scheduled and unscheduled absences of the Host Home family.
12. Have plans for when a Host Home family becomes unable to provide the services to someone on an immediate basis. The agency must ensure the availability of back-up plans to support the person until another suitable living arrangement can be secured.

F. Relief staffing may be provided in the individual's Host Home by another certified Host Home Family or by staff of the Host Home agency or in another Host Home Family's home.

G. Host Home Family components:

1. The principal caregiver in the Host Home must attend and participate in the meeting to develop the individual's Plan of Services and Supports (PSS).
2. The Host Home Family must follow all aspects of the individual's PSS and any support/activity plan (e.g. Plan of Services and Supports, Behavior Support Plan, nutrition plan, etc.) the individual might have.
3. The Host Home Family must take and assist the individual in attending appointments (i.e., medical, therapy, etc.).
4. The Host Home Family must provide transportation as would a natural family member.
5. The principal caregiver must maintain required documentation.
6. The Host Home Family must meet all staff training requirements as outlined in the DMH Operational Standards.
7. The Host Home Family and/or principal caregiver must participate in all training provided by the Host Home agency.

8. The principal caregiver must maintain all documentation as required in the DMH Record Guide.

H. The Host Home agency is responsible for ensuring the individual has basic furnishings in his/her bedroom if those furnishings are not available from another resource such as Bridge to Independence (Money Follows the Person) or Transition Assistance through the ID/DD waiver. Basic furnishings include: bed frame, mattress, box springs if needed, chest of drawers, and appropriate lighting.

I. Individuals receiving Host Home services are not eligible for Home and Community Supports, Shared Supported Living, Supported Living, Supervised Living, In-Home Nursing Respite, In-Home Respite or Community Respite.

L. Individuals receiving Host Home services must be determined to be able to self-administer their medication(s).

M. Individuals receiving Host Home services must have access to the community to the same degree as people not receiving services. This includes access to leisure and other community participation activities.

Rule 30.4 Supported Living Services for IDD Service Components

K. Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living in the community. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency. Supported Living services are provided in a homelike setting where people have access to the community at large to the same extent as people who do not have a serious mental illness and/or IDD.

L. Supported Living Services are for individuals age 18 and above with serious mental illness and/or intellectual/developmental disabilities and are provided in residences in the community with four (4) or fewer individuals

M. Supported Living provides assistance with the following, depending on each individual's support needs:

6. Grooming
7. Eating
8. Bathing
9. Dressing
10. Personal hygiene.

N. Supported Living provides assistance with instrumental activities of daily living which include assistance with:

10. Planning and preparing meals
11. Transportation or assistance with securing transportation
12. Assistance with ambulation and mobility
13. Supervision of the individual's safety and security
14. Banking
15. Shopping
16. Budgeting
17. Facilitation of the individual's inclusion participation in community activities
18. Use of natural supports and

O. Providers must develop methods, procedures and activities to provide meaningful days and independent living choices about activities/services/staff for the individual(s) served in the community.

P. Procedures must be in place for individual(s) to access any other needed services as well as typical community services available to all people in order to facilitate meaningful days and development of natural supports.

Q. For individuals with IDD staff ratios are dependent upon the level of support required by the individual, not to exceed eight (8) hours per twenty-four (24) hour period.

R. Supported Living services for community participation activities may be shared by up to three (3) individuals who may or may not live together and who have a common direct service provider agency. In these cases, individuals may share Supported Living staff when agreed to by the individuals and when the health and welfare can be assured for each individual.

S. Individuals in Supported Living cannot also receive: Supervised Living, Host Home services, In-Home Nursing Respite, In-Home Respite, Home and Community Supports, or Community Respite.

T. Nursing services are a component part of ID/DD Waiver Supported Living. They must be provided as-needed, based on each individual's need for nursing services. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring; periodic assessment, etc.

Rule 30.5 Supported Living for IDD Environment and Safety

G. Each housing unit/house must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the home , (i.e., kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

H. Providers must document that all fire extinguishers are properly maintained and serviced. Homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

I. Each housing unit/house must have, at a minimum, operable carbon monoxide detector where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

J. In lieu of posted escape routes, providers must document training that prepares an individual to exit their housing unit/house in the event of emergency.

K. Training for Supported Living must take place upon admission and at least annually thereafter. Documentation is to be maintained in the person's record.

L. At least annually, training must be provided to adults individuals receiving Supported Living Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following:

1. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;
2. Fire, smoke and carbon monoxide safety and the use of detectors. If necessary, staff must assist in obtaining and mounting fire, smoke and carbon monoxide detectors;
3. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature, documenting such in a log to be maintained by the provider staff; and,
4. Any other health/safety issues based on the needs or identified risk for each individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 30.6 Shared Supported Living for IDD Service Components

A. Shared Supported Living services are for individuals age 18 and older who have IDD and are provided in compact geographical areas (e.g. an apartment complex) in residences either owned or lease by themselves or a provider. Staff supervision is provided at the program site and in the community but does not include direct staff supervision at all times. Waiver Supervised Living Program Supervisors may be limited to supervise less than 4 homes if deemed necessary by DMH.

1. The amount of staff supervision someone receives is based on tiered levels of support based on a person's score on the Inventory for Client and Agency Planning (ICAP).
2. There must be awake staff twenty-four (24) hours per day, seven (7) days per week when individuals are present. Staff must be able to respond to requests/need for

assistance from individuals receiving services within five (5) minutes at all times individuals are present at the program site.

B. Nursing services are a component part of ID/DD Waiver Shared Supported Living. They must be provided as-needed, based on each individual's need for nursing services. Examples of activities may include: Monitoring vital signs; monitoring blood sugar; setting up medication sets for self-administration; administration of medication; weight monitoring; periodic assessment, etc.

E. Shared Supported Living provides individuals assistance with direct personal care activities such as:

1. Grooming
2. Eating
3. Bathing
4. Dressing
5. Personal hygiene

F. Shared Supported Living provides assistance with instrumental activities of daily living which include:

1. Planning and preparing meals
2. Transportation
3. Ambulation and mobility
4. Supervision of the individual's safety and security
5. Banking
6. Shopping
7. Budgeting
8. Facilitation of the individual's ~~inclusion~~ participation in community activities
9. Use of natural supports and typical community services available to all people in order to facilitate meaningful days

F. Individuals have freedom and support to control their own schedules and activities.

1. Individuals cannot be made to attend a day program if they choose to stay home, would prefer to come home after a job or doctor's appointment in the middle of the day, if they are ill, or otherwise choose to remain at home.
2. Staff must be available to support individual choice.

F. All required staff must participate in the development and review of the person's Plan of Services and Supports.

Rule 30.7 Shared Supported Living for IDD Environment and Safety

G. Each housing unit/house must provide operable 2A-10B, C multi-purpose fire extinguishers in fixed locations that are readily accessible for use in the home , (i.e.,

flammable storage areas, kitchens, laundry areas, garages, gas water heater locations) and must be mounted in a secure manner.

H. Providers must document that all fire extinguishers are properly maintained and serviced. Homes must have evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years. Fire extinguishers that cannot be recharged for whatever reason must be replaced immediately.

I. Each housing unit/house must have, at a minimum, operable carbon monoxide detectors located where natural gas or any other source of carbon monoxide emission is used or where there is an open flame (e.g., gas heater, gas water heater, etc.). One carbon monoxide detector must be located in every one thousand (1,000) square foot area or less.

J. In lieu of posted escape routes, providers must document training that prepares an individual to exit their housing unit/house in the event of emergency.

K. Training must take place upon admission and at least quarterly thereafter. This documentation must be maintained on site, in each person's record.

L. At least annually, training must be provided to adults individuals receiving Supported Living Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following:

1. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;
2. Fire, smoke and carbon monoxide safety and the use of detectors. If necessary, staff must assist in obtaining and mounting fire, smoke and carbon monoxide detectors;
3. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature, documenting such in a log to be maintained by the provider staff; and,
4. Any other health/safety issues based on the needs or identified risk for each resident individual.

Source: Section 41-4-7 of the Mississippi Code, 1972, as amended

Part 2: Chapter 31: Community Living Services Individuals with Substance Use Disorders

Rule 31.1 General Community Living for Individuals with Substance Use Disorders

F. Substance Use Disorders Residential Treatment Services support individuals as they develop the skills and abilities necessary to improve their health and wellness, live self-directed lives, and strive to reach their full potential in a life of recovery. Services are offered in a community based treatment setting. The residential continuum of care includes both Primary Residential Services and Transitional Residential Services for individuals with SUD.

G. Staffing must be sufficient to meet service requirements. Male and female (as appropriate) staff must be on-site and available twenty-four (24) hours per day, seven (7) days per week.

H. Residential Services accommodating child residents must adhere to the following:

5. Provide adequate, secure, and supervised play space
6. Prohibit any form of corporal punishment by staff or individuals receiving services. Staff must provide residents with information regarding positive approaches to management of children's behavior.
7. Safety measures in place to prohibit access by any child perpetrators/offenders. This includes potential residents or visitors.

I. Programs serving children or youth must also comply with Rule 29.

J. Caseloads for residential services must have no more than twelve (12) adults or eight (8) adolescents assigned to a single therapist or counselor.

Rule 31.2 Substance Use Disorders Community Living Handbook

A. In addition to information contained in the provider's policy and procedure manual, providers of SUD Residential Treatment Services must develop a Handbook which includes all applicable policies and procedures. Handbooks are to be provided to the individual/parent/legal representative during orientation. The Community Living Handbook must be readily available for review by staff and must be updated as needed.

B. All providers must document that each individual (and/or parent/guardian) served is provided with a handbook during orientation on the day of admission. The provider must document the review of the handbook with the resident annually (if applicable to the service).

C. The service and site-specific handbook must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative.

F. Providers must have a written plan for providing the handbook information in a resident's language of choice when necessary if English is not their primary language.

E. At a minimum, the Handbook must address the following:

1. A person friendly, person first definition and description of the service being provided
2. The philosophy, purpose and overall goals of the service, to include but are not limited to:
   (a) Methods for accomplishing stated goals and objectives
   (b) Expected results/outcomes
   (c) Methods to evaluate expected results/outcomes
3. A description of how the service addresses the following items:
   (a) Visitation guidelines
   (b) External communication guidelines (phone, mail, email, etc.)
   (c) Dating
   (d) Off-site activities
   (e) Household tasks
   (f) Curfew
   (g) Use of items for personal consumption (i.e., tobacco, dietary supplements, OTC medications, food or drink items, etc.
   (h) Respecting the rights of other residents' privacy, safety, health and choices

4. A description of the meal schedule
5. Personal hygiene care and grooming expectations, including assistance available
6. Medication schedule
7. Guidelines for prevention of and protection from infection, including communicable diseases
8. Policy regarding the search of the individual's room, person and/or possessions including:
   (a) Circumstances in which a search may occur
   (b) Staff designated to authorize searches
   (c) Documentation of searches
   (d) Consequences of discovery of prohibited items
9. Policy regarding urine drug screening for prohibited/illegal substances including:
   (a) Circumstances in which screens may occur
   (b) Staff designated to authorize screening
   (c) Documentation of screening
   (d) Consequences of positive screening of prohibited substances
   (e) Consequences of refusing to submit to a screening
   (f) Process for individuals to confidentially report the use of prohibited substances prior to being screened

11. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights

H. Orientation of the individual to the service including:

5. Familiarization of the individual with the living arrangement and neighborhood
6. Introduction to support staff and other residents (if appropriate)
7. Description of the written materials provided upon admission (i.e., handbook, etc.)
8. Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission

I. Methods for assisting individuals in arranging and accessing routine and emergency medical and dental care including:

1. Agreements with local physicians and dentists to provide routine care
2. Agreements with local physicians, hospitals and dentists to provide emergency care
3. Process for gaining permission from parent/guardian, if necessary

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.3 Animals/Pets on the Premises

C. Providers must develop policies regarding pets and animals on the premises for all community living programs.

D. Animal/Pet policies must address, at a minimum, the following:

1. Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site
2. Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)
3. Procedures to ensure pets will be kept away from food preparation sites and eating areas
4. Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.4 Transitional Residential Services

C. Transitional Residential Services are provided in a safe and stable group living environment which promotes recovery while encouraging the pursuit of vocational or related opportunities.

D. An individual must have successfully completed a primary residential substance use disorder treatment program in order to be eligible for admission to transitional residential

services. The primary substance use disorder residential treatment program must be at least four (4) weeks long.

D. The program components include at a minimum:
   3. At least one (1) hour of individual therapy per week with each individual
   4. A minimum attendance of at least two (2) hours of group therapy per week. Group therapy must be offered at times that accommodate the schedules of the individuals
   3. Family therapy must be offered and available as needed. Documentation of attendance or refusal is required.
   8. Psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, vocation, education, employment, recovery, or related skills.
   5. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval)

E. A written master schedule of activities that documents the provision of the following services:

   1. Group therapy
   2. Psychoeducational groups
   3. Therapeutic and leisure/recreational/physical exercise activities

F. Employment for individuals in Transitional Residential Services must be community based and not as part of the onsite program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.5 Primary Residential Services

B. Primary Residential Services is the highest community based level of care for the treatment of substance use/addictive disorders. This level of treatment provides a safe and stable group living environment where the individual can develop, practice and demonstrate necessary recovery skills.

C. Individuals admitted into Primary Residential Services must receive a medical assessment within forty-eight (48) hours of admission to screen for health risks

F. Programs must ensure access to each of the following ~~services~~ professionals either through program staff or affiliation agreement/contract:

   1. A licensed psychiatrist or psychologist with experience in the treatment of substance use disorders or
   2. A licensed physician with experience in the treatment of substance use disorders.

G. The program components include at a minimum:

1. At least one (1) hour of individual therapy per week with each individual.
2. A minimum attendance of at least five (5) hours of group therapy per week with each individual.
3. Family therapy must be offered and available at least twice (2) during the course of treatment. Documentation of attendance or refusal by the individual or family is required.
4. At least twenty (20) hours of psychoeducational groups individualized to the residents. Topics to be address may include, but are not limited to, substance use disorders, self-help/personal growth, increasing self-esteem, wellness education, social skills, anger management, the recovery process, and a philosophy of living which will support recovery.
5. At least three (3) hours of family-oriented education activities during the course of treatment.
6. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval)
7. Vocational counseling and planning/referral for follow-up vocational services
8. For child/youth, an academic schedule indicating school hours.

H. A written master schedule that documents the provision of the following services:

1. Group therapy
2. Psychoeducational groups
3. Family-oriented education
4. Therapeutic and leisure/recreational/physical exercise activities
5. Vocational counseling and planning/referral
6. For child/youth, an academic schedule indicating school hours

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.6 Environment and Safety for Primary and Transitional Residential Services

G. Programs must adhere to environmental and safety requirements in this section that are in addition to or more stringent than the requirements in Chapter 13 and are specific to Primary and Transitional Services.

H. The provider must assign, maintain and document on-site staff coverage twenty-four (24) hours a day and seven (7) days a week with a staff member designated as responsible for the program at all times and male/female staff coverage when necessary.

I. All providers must ensure adequate visiting areas are provided for residents and visitors.

J. All providers must ensure the laundry room has an exterior mechanical ventilation system for the clothes dryer.

K. All programs must have separate storage areas for:

1. Sanitary linen;
2. Food (Food supplies cannot be stored on the floor.); and
3. Cleaning supplies.

F. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

G. All program of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system (all systems must be operable).

R. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas;

S. Programs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas;

T. Each bedroom must have at least two means of escape

U. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom; and,

V. Two (2) means of exit per living area must be provided and must be readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition.

W. Programs must have the capacity to monitor unauthorized entrance, egress, or movement through the facility; and,

X. Resident bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor. All windows must be operable.

Y. Resident bedrooms must meet the following dimension requirements:

1. Single room occupancy - at least one hundred (100) square feet
2. Multiple occupancy - at least eighty (80) square feet for each resident

Z. Resident bedrooms must house no more than three (3) persons each;

AA. Resident bedrooms must be appropriately furnished with a minimum of a single bed and chest of drawers and adequate storage/closet space for each resident;

R. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances;

S. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and

T. Each bed must be equipped with a minimum of one pillow and case, two sheets, bedspread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.

U. All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.

W. All programs must ensure bathtubs and showers are equipped with:

1. Soap dishes;
2. Towel racks;
3. Shower curtains or doors; and
4. Grab bars (as needed by the residents).

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

~~Part 2: Chapter 30: General Community Living~~

~~Rule 30.1 Types of Community Living Services~~

U. ~~Community Living Services are individually tailored supports that assist individuals with the acquisition, retention, or improvement of skills related to living independently in the community.~~

~~B. Community Living Services include any type of provider-managed living arrangements and/or services. There are three core types of Community Living Services: Supported Living, Supervised Living, and Host Homes. The level/type of service is determined by skills and needs of each individual.~~

~~C. Supported Living is provided to individuals who reside in their own residences (either owned or leased) for the purposes of increasing and enhancing independent living. Supported living is for individuals who need less than 24-hour staff support per day. Staff must be on call 24/7 in order to respond to emergencies via phone call or return to the living site, depending on the type of emergency.~~

~~D. Supervised Living is intended for individuals who are determined to need an array of supports and services provided with appropriate staff and resources to support an individual who needs assistance twenty-four (24) hours per day/seven (7) days per week to live in the community. Treatment Foster Care Services and Therapeutic Group Homes are intensive community-based Supervised Living services for children and youth with SED.~~

~~E. Host Homes are private homes where an individual lives with a family and receives personal care and supportive services. Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment.~~

~~F. Substance Use and Addictive Disorders Residential Treatment Services provide an array of supports to assist individuals with gaining the skills and abilities needed in order to live a life of recovery. Services are offered twenty-four (24) hours per day/seven (7) days per week in the community. The residential continuum of care includes both Primary Residential Services and Transitional Residential Services for individuals with SUAD.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 30.2 Community Living Handbook~~

~~A. In addition to information contained in the provider's policy and procedure manual, providers of each type of Community Living Service must develop a Handbook which includes all policies and procedures for provision of each community living service. Handbooks are to be provided to the individual/parent/legal representative during orientation. The Community Living Handbook must be readily available for review by staff and must be updated as needed.~~

~~B. All providers of Community Living Services (all types) must document that each individual (and/or parent/guardian) served in Community Living Services is provided with a handbook and orientation on the day of admission. The provider must document the review of the handbook with the resident annually (if applicable to the service).~~

~~C. All Community Living providers must have a written plan for soliciting input from residents to be included in all sections of the handbook.~~

~~D. The service and site-specific handbook must be written in a person-first, person-friendly manner that can be readily understood by the individual/parent/legal representative.~~

~~E. Community Living providers must have a written plan for providing the handbook information in a resident's language of choice when necessary if English is not their primary language.~~

~~F. The Community Living handbook may not be a book of rules.~~

~~G. The Handbook may not include any rules or restrictions that infringe on or limit the individual's ability to live in the least restricted environment possible or that limit or restrict the rights of individuals receiving services specified in Chapter 14 of these standards.~~

~~H. At a minimum, the Community Living Handbook must address the following:~~

~~1. A person friendly, person first definition and description of the community living service being provided;~~
~~2. The philosophy, purpose and overall goals of the service, to include but are not limited to:~~
~~(a) Methods for accomplishing stated goals and objectives~~
~~(b) Expected results/outcomes~~
~~(c) Methods to evaluate expected results/outcomes.~~

~~3. Description of the service components, including the minimum levels of staffing required for the safety and guidance of individuals to be served~~
~~4. A description of how the community living service addresses the following items, to include but not limited to:~~

~~(a) Visitation guidelines (applying to family, significant others, friends and other visitors) that are appropriate to the type of community living~~

~~(Exception: visitation guidelines are not required for Supported Living Services)~~

~~(1) Individual's right to define their family and support systems for visitation purposes unless clinically/socially contraindicated~~

~~(2) All actions regarding visitors (restrictions, defining individual and family support systems, etc.) must be documented in the individual's case record~~

~~(3) Any restrictions on visitors must be reviewed whenever there is an identified need or request by the individual to change any of the restrictions~~

~~(4) Visitation rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.~~

~~(5) To the greatest extent possible, individuals should have visitors of their choosing at any time.~~

~~(b) Daily private communication (phone, mail, email, etc.) without hindrance unless clinically contraindicated (Exception: Supported Living Services):~~

~~(1) Any restrictions on private telephone use must be reviewed daily~~

~~(2) All actions regarding restrictions on outside communication must be documented in the case record~~

~~(3) Communication rights must not be withheld as punishment and may not be limited in ways that unreasonably infringe on the individual's stated rights.~~

~~(c) Dating (Exception: Supported Living Services)~~

~~(d) Off-site activities (Exception: Supported Living Services)~~

~~(e) Household tasks (Exception: Supported Living Services)~~

~~(f) Curfew (Exception: Supported Living Services)~~

~~(g) Use of alcohol, tobacco and other drugs (Use of alcohol and/or tobacco may not be prohibited unless covered in the individuals ISP or specifically precluded in a lease or similar legal document);~~

~~(h) Respecting the rights of other residents' privacy, safety, health and choices.~~

~~5. Policy regarding the search of the individual's room, person and/or possessions (Exception: Unannounced searches may not be conducted in Supported Living and Host Home settings unless there is reason to believe that a crime has been committed), to include but not limited to;~~

~~(a) Circumstances in which a search may occur;~~

~~(b) Staff designated to authorize searches;~~

~~(c) Documentation of searches; and~~

~~(d) Consequences of discovery of prohibited items.~~

~~6. Policy regarding screening for prohibited/illegal substances (Exception: Staff may not screen for prohibited/illegal substances in Supported Living and Host~~

~~Home settings unless there is reason to believe that a crime has been committed; in which case, law enforcement should be contacted immediately), to include but not limited to:~~

~~(a) Circumstances in which screens may occur;~~
~~(b) Staff designated to authorize screening;~~
~~(c) Documentation of screening;~~
~~(d) Consequences of positive screening of prohibited substances;~~
~~(e) Consequences of refusing to submit to a screening; and~~
~~(f) Process for individuals to confidentially report the use of prohibited substances prior to being screened.~~

~~11. Orientation of the individual to Community Living Services, to include but not limited to:~~

~~(a) Familiarization of the individual with the living arrangement and neighborhood;~~
~~(b) Introduction to support staff and other residents (if appropriate)~~
~~(c) Description of the written materials provided upon admission (i.e., handbook, etc.); and~~
~~(d) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any program restrictions or limitations prior to or at the time of admission.~~

~~12. Methods for assisting individuals in arranging and accessing routine and emergency medical and dental care (Exception: Formal agreements described below may not be necessary or appropriate in Supported Living), to include but not limited to:~~

~~(a) Agreements with local physicians and dentists to provide routine care~~
~~(b) Agreements with local physicians, hospitals and dentists to provide emergency care~~
~~(c) Process for gaining permission from parent/guardian, if necessary.~~

~~T. Description of the staff's responsibility for implementing the protection of the individual and his/her personal property and rights (Exception: This degree of staff responsibility may not be necessary in Supported Living);~~

~~U. Determination of the need for and development, implementation and supervision of behavior change/management programs;~~

~~V. Description of how risks to health and safety of individuals in the program are assessed and the mitigation strategies put in place as a result of assessment; and,~~

~~W. Criteria for termination\discharge from the Community Living Service.~~

~~M. Providers of Supervised Living, must also address:~~

1. ~~A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared. Individuals must have access to food at any time, unless prohibited by his/her individual plan;~~
2. ~~Personal hygiene care and grooming, including any assistance that might be needed;~~
3. ~~Medication management (including storing and dispensing); and,~~
4. ~~Prevention of and protection from infection, including communicable diseases.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 30.3 Animals/Pets on the Premises~~

~~X. Providers must develop policies regarding pets and animals on the premises for all community living programs.~~

~~Y. Animal/Pet policies must address, at a minimum, the following:~~

1. ~~Documentation of vaccinations against rabies and all other diseases communicable to humans must be maintained on site~~
2. ~~Procedures to ensure pets will be maintained in a sanitary manner (no fleas, ticks, unpleasant odors, etc.)~~
3. ~~Procedures to ensure pets will be kept away from food preparation sites and eating areas~~
4. ~~Procedures for controlling pets to prevent injury to individuals living in the home as well as visitors and staff (e.g., animal in crate, put outside, put in a secure room, etc.).~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 30.4 All Community Living Services for Children/Youth with SED~~

~~A. Each child/youth (ages 5 to 16 years) must be enrolled in an appropriate educational program in the local school district or be enrolled in an educational program operated by the provider that meets the individualized educational needs of the child/youth and is accredited by the Mississippi Department of Education. The Community Living Handbook must describe how this occurs for the children/youth served.~~

~~B. Providers must provide a balance of age-appropriate, goal-oriented activities to meet the individualized needs and build on the strengths of the children/youth served in the program. Areas to be addressed by such programs in the Community Living Handbook must include the following:~~

1. Social skills development based on each child's diagnosis and functional assessment
2. Wellness education
3. Increasing self-esteem
4. Leisure activities
5. Substance abuse education/counseling
6. HIV/AIDS education and/or counseling
7. Education and counseling about sexually transmitted diseases.

C. Providers must describe how group and individual activities, as well as routines for the children and youth are planned and how these activities are related to objectives in the Individual Service Plans of children and youth served in the program. Daily and weekly schedule(s) of activities must be maintained on file for at least three (3) months.

D. Providers must obtain written permission from the parent or legal representative for the child/youth to participate in program activities away from the Supervised Living location.

E. Providers must ensure child/youth has a dental examination within sixty (60) days after admission and annually thereafter or have evidence of a dental examination within 12 months prior to admission to the Supervised Living program.

F. Providers must place a current, dated photograph of the child in his/her record within thirty (30) days of admission.

G. Providers of services to children/youth under the age of eighteen (18) must have on file an assurance signed by the Executive Director of the Supported Living Service provider stating compliance with the provisions of Public Law 103-227 (Pro-Children Act of 1994). Note: Providers funded by the DMH must have a current "Certification Regarding Environmental Tobacco Smoke."

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 30.5 Fee Agreements

A. In living arrangements in which the residents pay rent or room and board to the provider, there must be a written financial agreement which addresses, at a minimum, the following:

1. Procedures for setting and collecting fees (in accordance with Part 2: Chapter 10 Fiscal Management)
2. A detailed description of the basic charges agreed upon (e.g. rent, utilities, food, etc.)
3. The time period covered by each charge
4. The service(s) for which special charge(s) are made

5. ~~The written financial agreement must be explained to and reviewed with the individual/legal representative prior to or at the time of admission and at least annually thereafter or whenever fees are changed.~~
6. ~~A requirement that the individual's record contain a copy of the written financial agreement which is signed and dated by the individual/legal representative indicating the contents of the agreement were explained to them and they are in agreement with the contents.~~
7. ~~The written financial agreement must include language specifying the conditions, if any, under which an individual might be evicted from the living setting that ensures that the provider will arrange or coordinate an appropriate replacement living option to mitigate the likelihood that the individual will become homeless as a result of discharge/termination from the community living services.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Part 2: Chapter 31: Supported Living (Adults with SMI and/or IDD)~~

~~Rule 31.1 Service Components~~

~~A. Supported Living Services for adults age 18 and above with serious mental illness and/or intellectual/developmental disabilities are provided in residences in the community of six (6) or fewer people.~~

~~B. Supported Living is provided to individuals in their own residences (either owned or leased) for the purpose of increasing and enhancing independent living.~~

~~C. Supported Living provides individuals with direct personal care activities such as:~~

1. ~~Grooming~~
2. ~~Eating~~
3. ~~Bathing~~
4. ~~Dressing~~
5. ~~Personal hygiene.~~

~~D. Supported Living provides instrumental activities of daily living which include assistance with:~~

1. ~~Planning and preparing meals~~
2. ~~Transportation or assistance with securing transportation~~
3. ~~Assistance with ambulation and mobility~~
4. ~~Supervision of the individual's safety and security~~
5. ~~Banking~~

6. Shopping
7. Budgeting
8. Facilitation of the individual's inclusion in community activities
9. Use of natural supports and typical community services available to all people in order to facilitate meaningful days

E. Supported Living services may be shared by up to three (3) individuals who may or may not live together and who have a common direct service provider agency. In these cases, individuals may share Supported Living staff when agreed to by the individuals and when the health and welfare can be assured for each individual.

F. Supported Living is not available to individuals receiving Supervised Living, Host Home services, In-Home Nursing Respite, Home and Community Supports, or Community Respite.

G. Providers must develop methods, procedures and activities to provide independent living choices for the individual(s) served in the community.

H. Procedures must be developed for individual(s) to access any other needed services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 31.2 Environment and Safety Specific to Supported Living

A. Providers of Supported Living Services are exempt from Health and Safety Standards in Part 2: Chapter 13, unless otherwise stated.

B. If the housing unit or complex is owned and/or operated by the provider agency, then each housing unit must have:

1. A fire extinguisher(s) compliant with the requirements of Part 2: Chapter 13;
2. Auditory smoke/fire alarms, with a noise level loud enough to awaken individuals. These alarms must be located in the kitchen, living area, each bedroom, and other applicable common rooms; and,
3. If the housing unit is supplied with gas or other type fuel that could create danger from carbon monoxide, the apartment/residence must have an alarm/detector to alert the individuals of potential danger.

C. At least annually, training must be provided to adults receiving any type of Supported Living Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following:

1. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;
2. Fire, smoke and carbon monoxide safety and the use of detectors. If necessary, staff must assist in obtaining and mounting fire, smoke and carbon monoxide detectors;

3. ~~Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature; and,~~
4. ~~Any other health/safety issues based on the needs or identified risk for each resident.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Part 2: Chapter 32: Environment and Safety for All Supervised Living~~

~~Rule 32.1 General~~

A. ~~This chapter applies to environmental and safety requirements that are in addition to or more stringent than the requirements in Chapter 13 and are specific to Supervised Living, with exceptions as indicated.~~

B. ~~All environmental and physical safety requirements for foster homes and therapeutic group homes are under the jurisdiction of the MS Department of Human Services. DMH is responsible for certifying and monitoring the therapeutic/clinical components of therapeutic foster care services and therapeutic group home services.~~

C. ~~The provider must assign, maintain and document on-site staff coverage twenty-four (24) hours a day and seven (7) days a week with a staff member designated as responsible at all times and male/female staff coverage when necessary.~~

D. ~~Supervised Living facilities must, to the maximum extent possible, duplicate a "home-like" environment.~~

E. ~~All providers must ensure that programs have furnishings that are safe, comfortable, appropriate, and adequate.~~

F. ~~All providers must ensure visiting areas are provided for residents and visitors:~~

1. ~~Supervised living programs (all types) serving up to twelve (12) residents must have at least one (1) visiting area;~~
2. ~~Supervised living programs (all types) serving thirteen (13) or more persons must have two (2) visiting areas;~~
3. ~~Each visiting area must have at least two (2) means of escape.~~

G. ~~All providers must ensure the laundry room has an exterior ventilation system for the clothes dryer.~~

H. ~~All programs must have separate storage areas for:~~
1. ~~Sanitary linen;~~

~~2. Food (Food supplies cannot be stored on the floor.); and~~
~~3. Cleaning supplies.~~

~~I. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.~~

~~J. Individuals share residences based on their choices.~~

~~F. Individuals have freedom and support to control their own schedules and activities.~~
~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 32.2 Fire Protection~~

~~A. All Supervised Living (all types) of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system;~~

~~B. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas;~~

~~C. Residential facilities using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas;~~

E. ~~Each bedroom must have at least two means of escape;~~

F. ~~The exit door(s) nearest the residents' bedrooms must not be locked in a manner that prohibits ease of exit.~~

G. ~~Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom; and,~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 32.3 Resident Bedrooms~~

~~A. Resident bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor if identified as a means of egress. All windows must be operable.~~

~~B. Resident bedrooms must meet the following dimension requirements:~~

~~1. Single room occupancy - at least one hundred (100) square feet~~
~~2. Multiple occupancy - at least eighty (80) square feet for each resident~~

3. ~~Children or youth group home – at least seventy-four (74) square feet for the initial occupant and an additional fifty (50) square feet for a second occupant.~~

C. ~~Resident bedrooms must be appropriately furnished with a minimum of a single bed and chest of drawers and adequate storage/closet space for each resident;~~

D. ~~Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances;~~

E. ~~Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and~~

H. ~~Each bed must be equipped with a minimum of one pillow and case, two sheets, spread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.~~

I. ~~Individuals have the freedom to furnish and decorate their own rooms.~~

J. ~~Bedrooms must have lockable entrances with appropriate staff having keys.~~

K. ~~Individuals share bedrooms based on their choices.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 32.4 Restrooms~~

A. ~~All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.~~

B. ~~All programs must ensure bathtubs and showers are equipped with:~~

1. ~~Soap dishes;~~
2. ~~Towel racks;~~
3. ~~Shower curtains or doors; and~~
4. ~~Grab bars (as needed by the residents).~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Part 2: Chapter 33: Supervised Living~~

~~Rule 33.1 General Supervised Living~~

A. ~~Supervised Living is available to Adults with SMI and/or IDD and Children/Youth with SED and/or IDD.~~

B. ~~Supervised Living providers must have staff on site twenty-four (24) hours per day, seven (7) days per week who are able to respond immediately to requests/needs for assistance. A staff member must be designated as responsible for the program at all times. Apartment settings with an apartment manager with responsibilities related to collection of fees, maintenance, etc., must also have treatment/support staff in the required staff ratios in order to be considered Supervised Living.~~

C. ~~Treatment Foster Care Services are a type of Supervised Living for children/youth with SED and/or IDD.~~

D. ~~Individuals receiving services are prohibited from having friends, family members, etc., living with them who are not also receiving services as a part of the Supervised Living program.~~

E. ~~The provider must have a designated site manager for each Supervised Living service site.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 33.2 Service Components for Supervised Living For All Individuals Served~~

E. ~~Supervised Living Services provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Habilitation, learning and instruction are coupled with the elements of support, supervision and engaging participation to reflect the natural flow of learning, practice of skills, and other activities as they occur during the course of an individual's day.~~

F. ~~In addition to A, Supervised Living Services must include:~~

~~3. Direct personal care assistance activities such as:~~

~~(a) Grooming~~
~~(b) Eating~~
~~(c) Bathing~~
~~(d) Dressing~~
~~(e) Personal hygiene~~

~~2. Instrumental activities of daily living which include:~~

~~(a) Assistance with planning and preparing meals~~
~~(b) Cleaning~~
~~(c) Transportation or assistance with securing transportation~~
~~(d) Assistance with ambulation and mobility~~
~~(e) Supervision of the individual's safety and security~~
~~(f) Banking~~
~~(g) Shopping~~

~~(h) Budgeting~~
~~(i) Facilitation of the individual's inclusion in community activities~~
~~(j) Use of natural supports and typical community services available to all people~~
~~(k) Social interaction~~
~~(l) Participation in leisure activities~~
~~(m)Development of socially valued behaviors~~
~~(n) Assistance with scheduling and attending appointments~~

~~3. Activities to promote independence as well as care and assistance with activities of daily living when the individual is dependent on others to ensure health and safety.~~
~~4. Assisting individuals in monitoring their health and/or physical condition and maintaining documentation of the following in each person's record. Such as:~~

~~(a) Assistance with making doctor/dentist/optical appointments;~~
~~(b) Transporting and accompanying individuals to such appointments; and~~
~~(c) Conversations with the medical professional, if the individual gives consent.~~

~~5. Transporting individuals to and from community activities, other places of the individual's choice (within the provider's approved geographic region), work, and other sites as documented in the individual plan.~~
~~6. Accommodations must be made when an individual(s) wants to remain at home rather than joining group activities or if the individual is ill and must stay home from day activities.~~
~~7. If Supervised Living staff members have been unable to participate in the development of the individual's plan, staff must be trained regarding the individual's plan prior to beginning work with the individual. This training must be documented.~~
~~8. Nursing services are considered a component of Supervised Living services and must be provided in accordance with the MS Nursing Practice Act.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 33.3 Supervised Living for Adults with SMI~~

~~B. In addition to the requirements in Rules 33.1 and 33.2, providers of Supervised Living Services for adults with SMI must adhere to the following:~~

~~1. At least one staff person must be physically on-site; and,~~
~~2. A maximum of twelve (12) individuals may reside in a single residence for programs initially certified after the effective date of these standards.~~
~~3. Supervised Living Services may be intensive, time-limited for adults with serious mental illness in order to provide readjustment and transitional living services for individuals discharged from a psychiatric hospital who have demonstrated mental, physical, social and emotional competency to function more independently in the community. These time-limited services may also be provided for individuals who need this service as an alternative to a more restrictive treatment setting.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 33.4 Treatment Foster Care Services~~

~~I. Treatment Foster Care (TFC) services are intensive community-based services for children with significant developmental, emotional or behavioral needs provided by mental health professional staff and trained foster parents, resource parents or group home providers who provide a therapeutic program for children and youth with serious emotional disturbances living in a resource home licensed by the Department of Human Services. All environmental and physical safety requirements for therapeutic foster homes are under the jurisdiction of the regulations of the MS Department of Human Services. DMH is not responsible for the licensing or monitoring of therapeutic foster homes. DMH is responsible for the certification of the therapeutic services provided.~~

~~J. TFC providers can use only adults with current documentation of foster parent or resource family approval from the Mississippi Department of Human Services.~~

~~K. Each foster home or resource home must have no more than one (1) child/youth with serious emotional disturbance placed in the home at a given time. Siblings with serious emotional disturbance may be placed together in the same home if all of the following conditions apply:~~

~~7. The siblings have never been separated;~~
~~8. The siblings are not a danger to others; and~~
~~9. Therapeutic resource parents asked to place siblings in their home must consent, in advance in writing, to the placement. This documentation must be maintained in the individual record of each sibling.~~

~~D. Each TFC provider licensed for a minimum of ten (10) foster homes or resource homes must have a full-time director with overall administrative and supervisory responsibility for the services.~~

~~3. If the TFC provider is certified for fewer than ten (10) homes, the director can have administrative or supervisory responsibility for other services or programs; however, documentation must be maintained that at least fifty percent (50%) of the director's time is spent in administration and supervision of the TFC services.~~

~~E. Each TFC provider licensed for ten (10) to thirty (30) foster homes or resource homes must have one full-time Treatment Foster Care specialist whose services target the therapeutic foster parents or resource families. The TFC specialist's specific responsibilities must include at least the following:~~

~~1. Recruitment and training of therapeutic foster parents or therapeutic resource parents~~
~~2. Conducting interviews and other necessary work to appropriately place individual children and youth with prospective therapeutic foster care or resource parents~~

3. Maintenance of regular contacts with therapeutic foster care or resource families and provide documentation of those contacts in the case records
4. Performance of other foster parent or resource family support activities, as needed.

F. If the TFC provider is licensed for fewer than ten (10) foster or resource homes, the TFC specialist can have other responsibilities; however, documentation must be maintained that at least ten percent (10%) of his/her time for every one (1) therapeutic foster home or resource home is spent in performing duties of the TFC specialist/community support specialist.

G. The TFC specialist must have face-to-face contact with each therapeutic foster or resource parent(s) at least two (2) times per month, with at least one (1) of the two (2) contacts made during a home visit. All contacts of the TFC specialist with the therapeutic foster or resource parent(s) must be documented in the individual case record of the therapeutic resource parent(s).

H. All clinical/mental health therapeutic services for all children receiving TFC services must be provided by a staff member who holds a Master's degree and professional license or who is a DMH Certified Mental Health Therapist, DMH Certified Intellectual and Developmental Disabilities Therapist or a DMH Certified Addiction Therapist (when appropriate for the individual receiving services and the service being provided).

I. TFC Services must include individual therapy, family therapy, TFC support groups for children and TFC families, annual psychiatric evaluation, and twenty-four (24) hour per day and seven (7) days a week emergency services and crisis intervention. Group therapy may also be provided.

L. Each TFC provider must have one (1) full-time professionally licensed or DMH credentialed mental health therapist for every twenty (20) foster children/youth in the TFC program. The mental health therapist(s) for the TFC services must serve only in the mental health therapist role (i.e. cannot serve as the director or the TFC specialist).

M. The mental health therapist is required to have at least one individual therapy session per week with the child/youth. At least one family session per month is required with the resource parent(s).

N. A licensed psychiatrist with experience working with children/youth, on an employment or contractual basis, must be available for youth served by the TFC provider.

O. All resource parents must complete annual training as required in Part 2: Chapter 12. Topics should be addressed from a family perspective.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 33.5 Therapeutic Group Homes

~~K. Treatment Foster Care Services may also be provided to children/youth in a Therapeutic Group Home setting.~~

~~L. The maximum bed capacity of each TGH is ten (10) beds per home for children and youth twelve (12) years of age through age twenty (20) years and (11) eleven months and eight (8) beds for children and youth ages six (6) years through eleven (11) years and eleven (11) months. The Mississippi DMH may require a lower bed capacity than described in this standard, depending on the age, developmental or level of functioning, or intensity of need for intervention and supervision of the population of children and youth served in the individual home.~~

~~M. There may not be more than two (2) children/youth per bedroom in a Therapeutic Group Home.~~

~~D. The provider must ensure that the staff on-site is of a sufficient number to provide adequate supervision of child/youth in a safe, therapeutic home environment and must meet the following minimum requirements:~~

~~13. In TGH's with five (5) or fewer children or youth, at least one (1) staff member (which can be a direct care worker or house parent) with a least a Bachelor's degree in a mental health or related field must be assigned to direct service responsibilities for the children/youth during all hours.~~

~~14. For TGH's with six (6) to ten (10) children or youth, at least two (2) staff must be assigned to direct service responsibilities during all hours children or youth are awake and not in school. One (1) of the two (2) staff can be a direct care worker or house parent and one must be a professional staff member with at least a Bachelor's degree in a mental health or related field.~~

~~15. Have a full-time director who is on-site at least forty (40) hours per week.~~

~~16. Other appropriate professional staff must be available to assist in emergencies, at least on an on-call basis, at all times.~~

~~17. DMH may require a staff to youth ratio lower than described above, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of children or youth served by the individual home.~~

~~E. A licensed psychiatrist and a professionally licensed or DMH credentialed mental health therapist with experience working with children/youth must be available for children/youth served by the TGH.~~

~~F. Programs must provide each child/youth with therapeutic activities and experience in the skills they need to support a successful transition to a less restrictive setting or level of service.~~

~~G. Children/youth in the TGH program must receive Treatment Foster Care Services as described above. Documentation must be maintained in the case records of the children/youth~~

~~indicating the progress/results of the Treatment Foster Care Services.~~

~~H. Transition plans must be developed within ninety (90) days prior to completion of a TGH program and be included in the child/youth's record~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 33.6 Supervised Living for Individuals with Intellectual/Developmental Disabilities~~

A. ~~In addition to the requirements in Rules 33.1 and 33.2, providers of Supervised Living Services for individuals with intellectual/developmental disabilities must adhere to the following:~~

~~1. At least one staff person must be able to respond immediately to the requests/needs for assistance from the individuals in the program. An immediate response is defined as being within 3 minutes of the request unless the individual's plan (Plan of Services and Supports) indicates a lesser timeframe is needed.~~
~~2. A maximum of six (6) individuals may reside in a single residence.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 33.7 Host Homes for Individuals with Intellectual/Developmental Disabilities~~

~~A. Host Homes are private homes where no more than one individual who is at least 18 years of age lives with a family and receives personal care and supportive services.~~

~~B. Host Home Families are a stand-alone family living arrangement in which the principal caregiver in the Host Home assumes the direct responsibility for the participant's physical, social, and emotional well-being and growth in a family environment.~~

~~C. Host Home services include assistance with personal care, leisure activities, social development, family inclusion, community inclusion, and access to medical services. Natural supports are encouraged and supported. Supports are to be consistent with the participant's skill level, goals, and interests.~~

~~D. Host Homes are administered and managed by provider agencies that are responsible for all aspects of Host Home Services. Host Home agencies must:~~

~~1. Ensure availability, quality and continuity of Host Homes;~~
~~2. Take into account compatibility with the Host Home Family member(s) including age, support needs, and privacy needs;~~
~~3. Provide each individual receiving Host Home services with his/her own bedroom;~~
~~4. Recruit, train, and oversee the Host Home Family (training must be approved by DMH);~~

5. ~~Have 24-hour responsibility for the Host Homes which includes back-up staffing for scheduled and unscheduled absences of the Host Home family.~~

E. ~~Relief staffing may be provided in the individual's Host Home by another Host Home Family or by staff of the Host Home agency or in another Host Home Family's home.~~

F. ~~Host Home Family components:~~

1. ~~The principal caregiver in the Host Home must attend and participate in the meeting to develop the individual's Plan of Services and Supports (PSS).~~
2. ~~The Host Home Family must follow all aspects of the individual's PSS and any support/activity plan the individual might have~~
3. ~~The Host Home Family must assist the individual in attending appointments (i.e., medical, therapy, etc.)~~
4. ~~The Host Home Family must provide transportation as would a natural family member~~
5. ~~The principal caregiver must maintain required documentation~~
6. ~~The Host Home Family must meet all staff training requirements as outlined in the DMH Operational Standards.~~
7. ~~The Host Home Family and/or principal caregiver must participate in all training provided by the Host Home agency.~~

G. ~~The Host Home agency is responsible for ensuring the individual has basic furnishings in his/her bedroom if those furnishings are not available from another resource such as Bridge to Independence (Money Follows the Person) or Transition Assistance through the ID/DD waiver.~~

H. ~~Individuals receiving Host Home services are not eligible for Home and Community Supports, Supported Living, Supervised Living, In-Home Nursing Respite, or Community Respite.~~

I. ~~Individuals receiving Host Home services must be determined to be able to self-administer their medication(s).~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Part 2: Chapter 34: Environment and Safety~~

~~Rule 34.1 Environment and Safety Specific to Supervised Living Services~~

A. ~~This chapter applies to environmental and safety requirements that are in addition to or more appropriate to Supervised Living than the requirements in Chapter 13. This chapter is not applicable to Host Home Services.~~

~~B. Providers must provide furnishing used in common areas (den, dining, and bathrooms), kitchen supplies, cleaning supplies, and at least 2 sets bath towels, hand towels, wash cloths per person.~~

~~C. Providers are responsible for bedroom furnishings (bed frame, mattress, box springs if needed, chest, night stand and lamp) if (a) the individual does not have these items or (b) these items are not provided through Bridge to Independence (Money Follows the Person) or Transition Assistance through the ID/DD waiver.~~

~~D. Supervised Living facilities must, to the maximum extent possible, duplicates a "home-like" environment.~~

~~E. All providers must ensure visiting areas are provided for residents and visitors:~~

~~1. Supervised living programs (all types) serving up to twelve (12) residents must have at least one (1) visiting area;~~
~~2. Supervised living programs (all types) serving thirteen (13) or more persons must have two (2) visiting areas;~~
~~3. Each visiting area must have at least two (2) means of escape.~~

~~F. All providers must provide access to a washer and dryer in the home, apartment, or apartment complex and must ensure the laundry room or area has an exterior ventilation system for the clothes dryer.~~

~~G. All programs must have separate storage areas for:~~

~~1. Sanitary linen;~~
~~2. Food (food supplies cannot be stored on the floor); and~~
~~3. Cleaning supplies.~~

~~H. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.~~

~~I. Fire Protection~~

~~1. All Supervised Living settings of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system.~~
~~2. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas.~~
~~3. Supervised Living settings using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas.~~
~~4. Each bedroom must have at least two means of escape.~~

5. ~~The exit door(s), nearest the residents' bedrooms, must remain unlocked and be able to be opened with a closed fist from the inside while remaining locked from the outside.~~
6. ~~Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom.~~
7. ~~Two (2) means of exit per living area must be provided and must be readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition.~~

~~J. Resident Bedrooms~~

1. ~~Resident bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor. All windows must be operable.~~
2. ~~Resident bedrooms must meet the following dimension requirements:~~

   ~~(a) Single room occupancy - at least one hundred (100) square feet~~
   ~~(b) Multiple occupancy - at least eighty (80) square feet for each resident~~
   ~~(c) Children or youth group home — at least seventy-four (74) square feet for the initial occupant and an additional fifty (50) square feet for a second occupant.~~

3. ~~Resident bedrooms must house no more than two (2) persons each;~~
4. ~~Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances;~~
5. ~~Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and~~

~~K. Restrooms~~

1. ~~All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.~~
2. ~~All programs must ensure bathtubs and showers are equipped with:~~

   ~~(a) Soap dishes;~~
   ~~(b) Towel racks;~~
   ~~(c) Shower curtains or doors; and~~
   ~~(d) Grab bars as needed by residents.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

Part 2: Chapter 32 ~~35~~: Programs of Assertive Community Treatment (PACT)

Rule 32.1 ~~35.1~~ Service Components of Programs of Assertive Community Treatment (PACT)

B. A Program of Assertive Community Treatment (PACT) is an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

B. The important characteristics of Programs of Assertive Community Treatment (PACT) are:

6. PACT serves individuals who may have gone without appropriate services. Consequently, the individual group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.

7. PACT services are delivered by a group of multidisciplinary mental health staff who work as a team and provide the majority of the treatment, rehabilitation, and support services individuals need to achieve their goals. Many, if not all, staff share responsibility for addressing the needs of all individuals requiring frequent contact.

8. PACT services are individually tailored with each individual and address the preferences and identified goals of each individual. The approach with each individual emphasizes relationship building and active involvement in assisting individuals with severe and persistent mental illness to make improvements in functioning, to better manage symptoms, to achieve individual goals, and to maintain optimism.

9. The PACT team is mobile and delivers services in community locations to enable each individual to find and live in their own residence and find and maintain work in community jobs rather than expecting the individual to come to the program.

10. PACT services are delivered in an ongoing rather than time-limited framework to aid the process of recovery and ensure continuity of caregiver. Severe and persistent mental illnesses are episodic disorders and many individuals benefit from the availability of a longer-term treatment approach and continuity of care. This allows individuals opportunity to decompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.2 ~~35.2~~ PACT Staffing

A. Each PACT team must have the organizational capacity to provide a minimum staff-to-individual ratio of at least one (1) full-time equivalent (FTE) staff person for every ten (10) individuals (this ratio does not include the psychiatrist or psychiatric nurse practitioner and the program assistant).

B. Each PACT team must have sufficient numbers of staff to provide treatment, rehabilitation, and support services twenty-four (24) hours a day, seven (7) days per week.

C. In addition to meeting the qualifications outlined in Part 2: Chapter 11, the following positions are required for PACT Teams:

1. Team Leader: A full-time team leader/supervisor who is the clinical and administrative supervisor of the team and who also functions as a practicing clinician on the PACT team. At a minimum, this individual must have a Master's degree in a mental health or related field and professional license or DMH credentials as a Certified Mental Health Therapist.
2. Psychiatrist/Psychiatric Nurse Practitioner: A psychiatrist/psychiatric nurse practitioner, who works on a full-time or part-time basis for a minimum of sixteen (16) hours per week for every fifty (50) individuals. For teams serving over fifty (50) individuals, the psychiatrist/psychiatric nurse practitioner must provide an additional three hours per week for every fifteen (15) additional individuals admitted to the program (not including on call time.) The psychiatrist/psychiatric nurse practitioner provides clinical services to all PACT individuals; works with the team leader to monitor each individual's clinical status and response to treatment; supervises staff delivery of services; and directs psychopharmacologic and medical services.
3. At least two (2) Full-time registered nurses. A team leader with a nursing degree cannot replace one of the FTE nurses.
4. At least one (1) Master's level or above mental health professional (in addition to the team leader.)
5. At least one (1) Substance Abuse Specialist
6. At least one (1) Employment Specialist
7. At least one (1) FTE certified peer specialist. Peer specialists must be fully integrated team members.
8. The remaining clinical staff may be Bachelor's level and paraprofessional mental health workers who carry out rehabilitation and support functions. A Bachelor's level mental health worker has a Bachelor's degree in social work or a behavioral science, and work experience with adults with severe and persistent mental illness. A para-professional mental health worker may have a Bachelor's degree in a field other than behavioral sciences or have a high school degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-service needs. These paraprofessionals may have related training (e.g., certified occupational therapy assistant, home health care aide) or work experience (e.g., teaching) and life experience.
9. At least one (1) program assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of PACT, including managing medical records; operating and coordinating the management information system; maintaining

accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individuals.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.3 ~~35.3~~ PACT Admissions and Discharge

A. In order to be admitted into PACT services, individuals must meet the criteria outlined in this rule.

B. PACT Teams serve individuals with severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual (DSM) of the American Psychiatric Association that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Individuals with other psychiatric illnesses are eligible dependent on the level of the long-term disability. (Individuals with a primary diagnosis of a substance abuse disorder, intellectual disability or other Axis II disorders are not the intended individual group. Additionally, individuals with a chronically violent history may not be appropriate for this service.)

C. Individuals with significant functional impairments as demonstrated by at least one of the following conditions:

1. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; maintaining personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
2. Significant difficulty maintaining consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child-care tasks and responsibilities).
3. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

D. Individuals must have one or more of the following problems, which are indicators of continuous high-service needs (i.e., greater than eight hours per month):

1. High use of acute psychiatric hospitals (e.g., two [2] or more admissions per year) or psychiatric emergency services.
2. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
3. Coexisting substance abuse disorder of significant duration (e.g., greater than six [6]

months).

4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or in imminent risk of becoming homeless.
6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement if more intensive services are not available.
7. Difficulty effectively utilizing traditional office-based outpatient services.

E. Discharges from the PACT team occur when individuals and program staff mutually agree to the termination of services. This must occur when individuals:

1. Have successfully reached individually established goals for discharge, and when the individual and program staff mutually agrees to the termination of services.
2. Have successfully demonstrated an ability to function in all major role areas (i.e., work, social, self-care) without ongoing assistance from the program, without significant relapse when services are withdrawn, and when the individual requests discharge, and the program staff mutually agree to the termination of services.
3. Move outside the geographic area of PACT's responsibility. In such cases, the PACT team must arrange for transfer of mental health service responsibility to a PACT program or another provider wherever the individual is moving. The PACT team must maintain contact with the individual until this service transfer is implemented.
4. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable Individual Service Plan with the individual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.4 ~~35.4~~ PACT Contacts

A. The PACT team must have the capacity to provide multiple contacts during a week with individuals experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment, or having significant ongoing problems in daily living. These multiple contacts may be as frequent as two to three (2 – 3) times per day, seven (7) days per week and depend on individual need and a mutually agreed upon plan between individuals and program staff. Many, if not all, staff must share responsibility for addressing the needs of all individuals requiring frequent contact.

B. The PACT team must have the capacity to rapidly increase service intensity to an individual when his or her status requires it or an individual requests it.

C. The PACT team must provide a mean (i.e., average) of at least three (3) contacts per week for all individuals.

D. Each new PACT team must gradually build up its case load with a maximum admission rate of five (5) individuals per month.

E. The PACT team must be available to provide treatment, rehabilitation, and support activities seven (7) days per week. When a team does not have sufficient staff numbers to operate two (2) eight (8) hour shifts weekdays and one (1) eight (8) hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on an individual-by-individual basis (per the individual-centered comprehensive assessment and individualized Individual Service Plan) in the evenings and on weekends. This includes:

1. Regularly scheduling staff to cover individual contacts in the evenings and on weekends.
2. Regularly scheduling mental health professionals for on-call duty to provide crisis and other services the hours when staff are not working.
3. The team may arrange coverage through a reliable crisis-intervention service. The team must communicate routinely with the crisis-intervention service (i.e., at the beginning of the workday to obtain information from the previous evening and at the end of the workday to alert the crisis-intervention service to individuals who may need assistance and to provide effective ways for helping them). The crisis-intervention service should be expected to go out and see individuals who need face-to-face contact.
4. Regularly arranging for and providing psychiatric backup all hours the psychiatrist/psychiatric nurse practitioner is not regularly scheduled to work. If availability of the PACT psychiatrist/psychiatric nurse practitioner during all hours is not feasible, alternative psychiatric backup should be arranged (e.g., mental health center psychiatrist, emergency room psychiatrist).
5. If "3" or "4" occurs, memoranda of agreement or formal contracts should be established and kept on file by the provider.

F. Each PACT Team must set a goal of providing eighty-five percent (85 percent) of service contacts in the community in non-office-based or non-facility-based settings.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.5 ~~35.5~~ PACT Staff Communication and Planning

A. The PACT team must conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings will be conducted in accordance with the following procedures:

1. The PACT team must maintain a written daily log. The daily log provides:
   (a) A roster of the individuals served in the program; and
   (b) For each individual, a brief documentation of any treatment or service contacts that have occurred during the last twenty-four (24) hours and a concise, behavioral description of the individual's status that day.
2. The daily organizational staff meeting must commence with a review of the daily log to update staff on the treatment contacts which occurred the day before and to provide a systematic means for the team to assess the day-to-day progress and status of all individuals.

3. The PACT team, under the direction of the team leader, must maintain a weekly individual schedule for each individual. The weekly individual schedule is a written schedule of all treatment and service contacts that staff must carry out to fulfill the goals and objectives in the individual's Individual Service Plan. The team will maintain a central file of all weekly individual schedules.
4. The PACT team, under the direction of the team leader, must develop a daily staff assignment schedule from the central file of all weekly individual schedules. The daily staff assignment schedule is a written timetable for all the individual treatment and service contacts and all indirect individual work (e.g., medical record review, meeting with collaterals [such as employers, social security], job development, Individual Service Planning, and documentation) to be done on a given day, to be divided and shared by the staff working on that day.
5. The daily organizational staff meeting will include a review of all the work to be done that day as recorded on the daily staff assignment schedule. During the meeting, the team leader or designee will assign and supervise staff to carry out the treatment and service activities scheduled to occur that day, and the team leader will be responsible for assuring that all tasks are completed.
6. During the daily organizational staff meeting, the PACT team must also revise Individual Service Plans as needed, plan for emergency and crisis situations, and add service contacts to the daily staff assignment schedule per the revised Individual Service Plans.

B. The PACT team must conduct Individual Service Planning meetings under the supervision of the team leader and the psychiatrist/psychiatric nurse practitioner. These Individual Service Planning meetings must:

1. Convene at regularly scheduled times per a written schedule set by the team leader.
2. Occur and be scheduled when the majority of the team members can attend, including the psychiatrist/psychiatric nurse practitioner, team leader, and all members of the Individual Treatment Team.
3. Require individual staff members to present and systematically review and integrate individual information into a holistic analysis and prioritization of issues.
4. Occur with sufficient frequency and duration to make it possible for all staff:
   (a) to be familiar with each individual and their goals and aspirations;
   (b) to participate in the ongoing assessment and reformulation of issues/ problems;
   (c) to problem-solve treatment strategies and rehabilitation options;
   (d) to participate with the individual and the Individual Treatment Team in the development and the revision of the Individual Service Plan; and
   (e) to fully understand the Individual Service Plan rationale in order to carry out each individual's plan.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.6 ~~35.6~~ PACT Staff Supervision

A. Each PACT team must develop a written policy for clinical supervision of all staff

providing treatment, rehabilitation, and support services. The team leader and psychiatrist must assume responsibility for supervising and directing all staff activities. This supervision and direction must consist of:

6. Individual, side-by-side sessions in which the supervisor accompanies an individual staff member to meet with individuals in regularly scheduled or crisis meetings to assess staff performance, give feedback, and model alternative treatment approaches;
7. Participation with team members in daily organizational staff meetings and regularly scheduled Individual Service Planning meetings to review and assess staff performance and provide staff direction regarding individual cases;
8. Regular meetings with individual staff to review their work with individuals, assess clinical performance, and give feedback;
9. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, Individual Service Plans, Individual Service Plan reviews); and
10. Written documentation of all clinical supervision provided to PACT team staff.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.7 ~~35.7~~ PACT Required Services

B. Operating as a continuous treatment service, the PACT team must have the capability to provide comprehensive treatment, rehabilitation, and support services as a self-contained service unit. Services must minimally include the following (1-11):

1. Service Coordination/Individual Treatment Team
   (a) Each individual will be assigned one (1) member of the PACT team to serve as a service coordinator who coordinates and monitors the activities of the person's Individual Treatment Team (ITT) and the greater PACT team. The primary responsibility of the service coordinator is to work with the individual to write the Individual Service Plan, to provide individual supportive counseling, to offer options and choices in the Individual Service Plan, to ensure that immediate changes are made as the individual's needs change, and to advocate for the individual's wishes, rights, and preferences. The service coordinator is also the first staff person called on when the individual is in crisis and is the primary support person and educator to the individual and/or individual's family. Members of the individual's treatment team share these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Service coordination also includes coordination with community resources, including consumer self-help and advocacy organizations that promote recovery.
   (b) Each individual will be assigned to Individual Treatment Team (ITT.) The ITT is a group or combination of three (3) to five (5) PACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned to work with an individual receiving services by the team leader and the psychiatrist/psychiatric nurse practitioner by the time of the first Individual Service Planning meeting or thirty (30) days after admission. The core members of the ITT are the service coordinator, the psychiatrist/psychiatric nurse

practitioner, and one (1) clinical or rehabilitation staff person who shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The ITT has continuous responsibility to: 1) be knowledgeable about the individual's life, circumstances, goals and desires; 2) collaborate with the individual to develop and write the Individual Service Plan; 3) offer options and choices in the Individual Service Plan; 4) ensure that immediate changes are made as an individual's needs change; and 5) advocate for the individual's wishes, rights, and preferences. The ITT is responsible to provide much of the individual's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles with the individual as specified by the individual and the ITT in the Individual Service Plan.

2. Crisis Assessment and Intervention
   (a) Crisis assessment and intervention must be provided twenty-four (24) hours per day, seven (7) days per week. These services will include telephone and face-to-face contact and will be provided in conjunction with the local community mental health system's emergency services program as appropriate.
   (b) A system must be in place that assures the individual can contact the PACT as necessary.

3. Symptom Assessment and Management include but not limited to the following:
   (g) Ongoing comprehensive assessment of the individual's mental illness symptoms, accurate diagnosis, and the individual's response to treatment.
   (h) Psycho-education regarding mental illness and the effects and side effects of prescribed medications.
   (i) Symptom-management efforts directed to help each individual identify/target the symptoms and occurrence patterns of his or her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.
   (j) Individual supportive therapy.
   (k) Psychotherapy.
   (l) Generous psychological support to individuals, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.

4. Medication Prescription, Administration, Monitoring and Documentation
   (a) The PACT team psychiatrist/psychiatric nurse practitioner must:
      (1) Establish an individual clinical relationship with each individual.
      (2) Assess each individual's mental illness symptoms and provide verbal and written information about mental illness.
      (3) Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist/psychiatric nurse practitioner will follow.
      (4) Provide education about medication, benefits and risks, and obtain informed consent.
      (5) Assess and document the individual's mental illness symptoms and behavior

in response to medication and monitor and document medication side effects.

(6) Provide psychotherapy.

(d) All PACT team members must regularly assess and document the individual's mental illness symptoms and behavior in response to medication and must monitor for medication side effects. This information should be shared with the prescriber.

(e) The PACT team program must establish medication policies and procedures which identify processes to:

(1) Record physician orders;
(2) Order medication;
(3) Arrange for all individual medications to be organized by the team and integrated into individuals' weekly schedules and daily staff assignment schedules;
(4) Provide security for medications (e.g., daily and longer-term supplies, long-term injectables, and longer term supplies) and set aside a private designated area for set up of medications by the team's nursing staff;
(5) Administer medications per state law to individuals receiving PACT services; and
(6) Comply with Rule 13.8.

5. Co-Occurring Substance Abuse Services

(a) Co-Occurring Substance Abuse Services are the provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has individual-determined goals. This must include but is not limited to individual and group interventions in:

(1) Engagement (e.g., empathy, reflective listening, avoiding argumentation).
(2) Assessment (e.g., stage of readiness to change, individual-determined problem identification).
(3) Motivational enhancement (e.g., developing discrepancies, psycho-education).
(4) Active treatment (e.g., cognitive skills training, community reinforcement).
(5) Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

6. Work-Related Services

a. Work-related services to help individuals value, find, and maintain meaningful employment in community-based job sites and services to develop jobs and coordinate with employers but also includes but is not necessarily limited to:

(1) Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
(2) Assessment of the effect of the individual's mental illness on employment

with identification of specific behaviors that interfere with the individual's work performance and development of interventions to reduce or eliminate those behaviors and find effective job accommodations.

(3) Development of an ongoing employment plan to help each individual establish the skills necessary to find and maintain a job.

(4) Individual supportive therapy to assist individuals to identify and cope with mental illness symptoms that may interfere with their work performance.

(5) On-the-job or work-related crisis intervention.

(6) Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

7. Activities of Daily Living

(a) Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist individuals to gain or use the skills required to:

(7) Find housing which is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate; landlord negotiations; cleaning, furnishing, and decorating); and procuring necessities (such as telephones, furnishings, linens).

(8) Perform household activities, including house cleaning, cooking, grocery shopping, and laundry.

(9) Carry out personal hygiene and grooming tasks, as needed.

(10) Develop or improve money-management skills.

(11) Use available transportation.

(12) Have and effectively use a personal physician and dentist.

8. Social/Interpersonal Relationship and Leisure-Time Skill Training

(a) Services to support social/interpersonal relationships and leisure-time skill training include supportive individual therapy (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure individuals' time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:

(6) Improve communication skills, develop assertiveness, and increase self-esteem.

(7) Develop social skills, increase social experiences, and develop meaningful personal relationships.

(8) Plan appropriate and productive use of leisure time.

(9) Relate to landlords, neighbors, and others effectively.

(10) Familiarize themselves with available social and recreational

opportunities and increase their use of such opportunities.

9. Peer Support Services

   (a) Services to validate individuals' experiences and to guide and encourage individuals to take responsibility for and actively participate in their own recovery. In addition, services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce individuals' self-imposed stigma;
   (b) Peer counseling and support; and
   (c) Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.

10. Support Services

   (a) Support services or direct assistance to ensure that individuals obtain the basic necessities of daily life, including but not necessarily limited to:
      (7) Medical and dental services;
      (8) Safe, clean, affordable housing;
      (9) Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance);
      (10) Social services;
      (11) Transportation; and
      (12) Legal advocacy and representation.

11. Education, Support, and Consultation to Individuals' Families and Other Major Supports

   (a) Services provided regularly under this category to individuals' families and other major supports, with individual agreement or consent, include:
      (1) Individualized psycho-education about the individual's illness and the role of the family and other significant people in the therapeutic process;
      (2) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people;
      (3) Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family;
      (4) Introduction and referral to family self-help programs and advocacy organizations that promote recovery;
      (5) Assistance to individuals with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

         i. Services to help individuals throughout pregnancy and the birth of a child;
         ii. Services to help individuals fulfill parenting responsibilities and coordinate services for the child/children; and
         iii. Services to help individuals restore relationships with children who are not in the individual's custody.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 32.8 ~~35.8~~ PACT Stakeholder Advisory

C. The PACT team must have a stakeholder advisory group to support and guide PACT team implementation and operation. The stakeholder advisory group must be made up of at least 51 percent (51%) mental health consumers and family members and include other community stakeholders such as representatives from services for the homeless, consumer-support organizations, food-shelf agencies, faith-based groups, criminal justice system, housing authorities, landlords, employers, and/or community colleges. Group membership must also represent the cultural diversity of the local population.

D. The stakeholder advisory group must:

1. Promote quality PACT model programs;
2. Monitor fidelity to the PACT program standards;
3. Guide and assist with the administering agency's oversight of the PACT program;
4. Problem-solve and advocate to reduce system barriers to PACT implementation;
5. Review and monitor individual and family grievances and complaints; and
6. Promote and ensure individuals' empowerment and recovery values in assertive community treatment programs.

C. The PACT team must have a system for regular review of the service that is designed to evaluate the appropriateness of admissions to the program, treatment or service plans, discharge practices, and other factors that may contribute to the effective use of the program's resources.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 33 ~~36~~: Adult Making A Plan (AMAP) Teams

Rule 33.1 ~~36.1~~ AMAP – General Requirements

G. Adult Making a Plan (AMAP) Teams address the needs of adults, ~~21~~ 18 years and above, with serious mental illness or dually diagnosed (SMI/DD or SMI/~~A&D~~SUAD) who have frequent/multiple placements in inpatient psychiatric services which could possibly be prevented with the coordinated efforts of multiple agencies and services.

H. Each AMAP Team must have a staff member identified as the Coordinator employed by the ~~CMHC~~ provider who has a Bachelor's degree. In addition, the following team members are recommended and should be present and documented at each AMAP Team meeting (if applicable):

1. The individual being referred to the AMAP Team, family member, and/or advocate representing the individual.
2. The individual's therapist, community support specialist, or other staff from the ~~local CMHC~~ provider which have detailed knowledge of the individual.
3. A representative of the Chancery Clerks office or Chancery Court.
4. A representative of the sheriff's department of the county in which the individual resides; and/or representative of the police department of the city of residence.
5. Staff from the regional behavioral health program or crisis stabilization unit that has had frequent contact with the individual.

I. The ~~Community Mental Health Center (DMH/C)~~ provider must maintain a current written interagency agreement with agencies participating in the AMAP Team.

J. The overall goal of the AMAP Team is to develop a new and different intervention for the individual in order for them to have a greater success of being maintained in a community setting. Past course of treatment and altered future service plan and completion of Crisis Support Plan must be documented on the Case Summary Form.

K. AMAP Team Monthly Reporting form and AMAP Team Case Summary forms must be submitted to DMH with each cash reimbursement request (if funding is available) and must also be maintained on-site with the AMAP Team Coordinator.

L. For any individuals who have been previously referred to the local AMAP Team to be placed at/committed to an inpatient psychiatric facility, the local AMAP Team must attempt to develop a less restrictive alternative in the community.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 33.2 ~~36.2~~ Access to AMAP Teams

A. All providers certified as Community Mental Health Centers (DHM/C) must have a minimum of one (1) AMAP Team Coordinator.

B. The AMAP Team Coordinator must provide information about the AMAP Team to all Chancery Clerks and Sheriff's Departments of every county in the CMHC catchment area.

C. The AMAP Team Coordinator must provide information about their AMAP Team (i.e. contact person, meeting schedule, etc.) to each state operated behavioral health facility, DMH certified Crisis Stabilization Unit that has a catchment area that their CMHC falls in, and the DMH Office of Consumer Support.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 34 ~~37~~: Access to Inpatient Care

Rule 34.1 ~~37.1~~ Referral

B. All providers certified as DMH/C or DMH/P must provide access to inpatient services in the individual's locale when appropriate.

B. The provider must have written policies and procedures for referral to inpatient services in the community, should an individual require such services.

C. The provider must maintain a current written agreement with a licensed hospital(s) to provide/make available inpatient services, which, at a minimum, addresses:

1. Identification of the provider's responsibility for the individual's care while the individual is in inpatient status;
2. Description of services that the hospitals will make available to individuals who are referred; and,
3. How hospital referral, admission and discharge processes are coordinated with crisis ~~emergency~~, Pre-Evaluation Screening, Civil Commitment Examination Services, and aftercare services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 34.2 ~~37.2~~ Pre-Evaluation Screening and Civil Commitment

B. Pre-Evaluation Screening and a Civil Commitment Examination are two separate events which include screening and examinations, inclusive of other services to determine the need for civil commitment and/or other mental health services, including outpatient or inpatient commitment. These services also include assessment and plans to link individuals with appropriate services and can only be provided by a DMH/C.

B. The ~~provider program~~ DMH/C must have a written plan that has been implemented which describes how the program meets the requirements of the Mississippi civil commitment statutes. This plan must describe by county:

1. The system for conducting Pre-Evaluation Screenings
2. The system for conducting Civil Commitment Examinations
3. The system for handling court appearances
4. The services that are offered for the family and/or significant others
5. The system for assuring that individuals being screened and/or evaluated for civil commitment and their family or significant others have access to a staff member knowledgeable in the civil commitment process.

C. The Pre-Evaluation Screening must be conducted by qualified staff of a regional CMHC, and

1. Be performed by:
   (a) A certified licensed psychologist or physician; or
   (b) A person with a Master's degree in a mental health or related field who has received training and certification in Pre-Evaluation Screening by the DMH; or,
   (c) Registered nurses who have received training and certification in Pre-Evaluation Screening by the DMH.
   (d) Additionally, staff who meet requirements (b) and (c) above, have completed and provide documentation of at least six (6) months of experience working with individuals with SMI or SED and;
2. Be performed in accordance with current Mississippi civil commitment statutes.
3. Be documented on the forms and provide the information required by the civil commitment law and/or the DMH.

D. If the Civil Commitment Examination is conducted, the examination must:

1. Be performed by two (2) licensed physicians, or one (1) licensed physician and either one (1) psychologist, nurse practitioner or physician assistant. The nurse practitioner or physician assistant conducting the examination shall be independent from, and not under the supervision of, the other physician conducting the examination (as required in MCA Section 41-21-67 (2)).
2. Be documented on required forms, and provide information required by law or the DMH. Documentation must include information in the individual record of the Commitment Examination results and the official disposition following the examination
3. Include the evaluation of the individual's social and environmental support systems
4. Include, when possible, the development of a treatment and follow-up plan for the individual and the family and/or significant others.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 35 ~~38~~: Designated Mental Health Holding Facilities

Rule 35.1 ~~38.1~~ Designation

E. Designated Mental Health Holding Facilities (hereafter referred to as "Holding Facility") ~~house~~ hold individuals who have been involuntarily civilly committed and are awaiting transportation to a treatment facility. The Holding Facility can be a county facility or a facility ~~with~~ in which the county contracts. DMH will conduct annual on-site visits to each Holding Facility to ensure they are in compliance with the standards in this Chapter.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.2 ~~38.2~~ Policies and Procedures

C. Each Holding Facility must have a manual that includes the written policies and procedures for operating and maintaining the facility ~~housing~~ holding individuals involved in the civil commitment process or those awaiting transportation to a certified/licensed mental health facility. ~~These~~ Written policies and procedures must give sufficient details for implementation and documentation of duties and functions so that a new employee or someone unfamiliar with the operation of the Holding Facility and services would be able to carry out necessary operations of the Holding Facility.

D. The policies and procedures must:

1. Be reviewed annually by the governing authority of the county, with advice and input from the regional Community Mental Health Center, as documented in the governing authority meeting minutes;
2. Be updated as needed, with changes approved by the governing authority before they are instituted, as documented in the governing authority meeting minutes. Changed sections, pages, etc., must show the date of approval of the revision on each page;
3. Be readily accessible to all staff on all shifts providing services to individuals in the Holding Facility, with a copy at each service delivery location;
4. Describe how the policies and procedures are made available to the public;
5. Have a copy of the Memorandum of Understanding (MOU) or contract between the Holding Facility and the Community Mental Health Center to describe how mental health services will be provided while people are ~~housed~~ being held in the Holding Facility.

C. A personnel record for each employee/staff member and contractual employee, as noted below, must be maintained and must include, but not be limited to:

1. The application for employment, including employment history and experience;
2. A copy of the current Mississippi license or certification for all licensed or certified personnel;
3. A copy of college transcripts, high school diploma, and/or appropriate documents to verify that educational requirements of the job description are met;

4. Documentation of an annual performance evaluation;
5. A written job description that shall include, at a minimum:
   (a) Job title;
   (b) Responsibilities of the job; and
   (c) Skills, knowledge, training/education and experience required for the job;
6. For contractual employees, a copy of the contract or written agreement which includes effective dates of the contract and which is signed and dated by the contractual employee and the Director of the Holding Facility or County Supervisor;
7. For all staff (including contractual staff) and volunteers, documentation must be maintained that a criminal records background check (including prior convictions under the Vulnerable Adults Act) and child registry check (for staff and volunteers who work with or may have to work with children) has been obtained and no information received that would exclude the employee/volunteer. (See Sections 43-15-6, 43-20-5, and 43-20-8 of the *Mississippi Code of 1972, Annotated*.) For the purposes of these checks, each employee/volunteer hired after July 1, 2002, must be fingerprinted;

D. Each facility shall have written procedures for admission of individuals who have been involuntarily civilly committed and awaiting transportation. These procedures shall include, but not be limited to, the following:

1. Make a complete search of the individual and his/her possessions;
2. Properly inventory and store individual's personal property;
3. Require any necessary personal hygiene activities (e.g., shower or hair care, if needed);
4. Issue clean, laundered clothing or appropriate garments (e.g., suicide risk reduction garments);
5. Issue allowable personal hygiene articles;
6. Perform health/medical screening;
7. Record basic personal data and information to be used for mail and visiting lists; and
8. Provide a verbal orientation of the individual to the facility and daily routines.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.3 ~~38.3~~ Staff Training

B. Supervisory and direct service staff who work~~s~~ with individuals ~~housed~~ being held in the Holding Facility as part of the civil commitment process must participate in training opportunities and other meetings, as specified and required by the Mississippi Department of Mental Health.

B. Documentation of training of individual staff must be included in individual training/personnel records and must include:

2. Date of training;
2. Topic(s) addressed;

3. Name(s) of presenter(s) and qualifications;
4. Contact hours (actual time spent in training).

C. Training on the following must be conducted and/or documented prior to service delivery for all newly hired staff (including contractual staff) and annually thereafter for all program staff. Persons who are trained in the medical field (i.e., physicians, nurse practitioners or licensed nurses) may be excluded from this prior training. Persons who have documentation that they have received this training at another program approved by the Department of Mental Health within the timeframe required may also be excluded:

11. First aid and life safety, including handling of emergencies such as choking, seizures, etc.;
12. Preventing, recognizing and reporting abuse/neglect, including provisions of the Vulnerable Adults Act, and the Mississippi Child Abuse Law;
13. Handling of accidents and roadside emergencies (for programs transporting only);
14. De-escalation techniques & crisis intervention;
15. Confidentiality of information pertaining to individuals being housed in the facility, including appropriate state and federal regulations governing confidentiality, particularly in addressing requests for such information;
16. Fire safety and disaster preparedness to include:
    (a) Use of alarm system;
    (b) Notification of authorities who would be needed/require contact in an emergency;
    (c) Actions to be taken in case of fire/disaster; and
    (d) Use of fire extinguishers;
17. Cardiopulmonary Resuscitation (CPR) certification ~~training (every two years);~~
18. Recognizing and reporting serious incidents, including completion and submission of reports;
19. Universal precautions for containing the spread of contaminants;
20. Adverse medication reaction and medical response; and
21. Suicide precautions.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.4 ~~38.4~~ Environment and Safety

C. If the designated mental health Holding Facility is being used for civil commitment purposes and is part of a correctional facility or jail, the individual(s) awaiting transfer related to civil commitment proceedings (or just individual(s) detained as part of the civil commitment process) must be ~~housed~~ held separately from pre-trial criminal offense detainees or inmates serving sentences.

D. Rooms used for ~~housing~~ holding individuals must be free from structures and/or fixtures that could be used ~~by detainees~~ to harm themselves.

C. Holding facilities must be inspected and approved by appropriate local and/or state fire, health/sanitation, and safety agencies at least annually (on or before anniversary date of previous inspection), with written records of fire and health inspections on file.

D. The following must be conducted immediately upon arrival:

1. Suicide assessment (using a DMH approved screening instrument); and
2. Violence risk assessment (using a DMH approved screening instrument)

E. If the risk level for any of these assessments is deemed "high", a twenty-four (24) hour follow-up assessment by nurse or physician is required.

F. If the risk level for suicide is deemed "high", immediate suicide prevention actions must be instituted.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.5 ~~38.5~~ Clinical Management

B. Each Holding Facility must have written procedures and documentation for clinical management of individuals who are involved in or have been involuntarily civilly committed and awaiting transportation. These procedures shall include, but not be limited to, the following:

1. Immediately upon arrival of the individual to the Holding Facility, all mental health screening information (pursuant to civil commitment procedures) must be made available to the Holding Facility staff;
2. Immediately upon arrival or within twenty-four (24) hours, a medical screening should be conducted and documented by a registered nurse or nurse practitioner that includes, at a minimum, the following components:
   (a) Vital signs (at a minimum: body temperature, pulse/heart rate, respiratory rate, & blood pressure);
   (b) Accu-Chek monitoring for persons with diabetes;
   (c) Medical/drug history;
   (d) Allergy history; and
   (e) Psychiatric history (refer to pre-evaluation form).

B. Clinical Management of the individual being held must include:

1. Within seventy-two (72) hours of admission, individuals should be assessed by a Physician, preferably a psychiatrist or a Nurse practitioner, preferably a psychiatric nurse practitioner;
2. Twenty-four (24) hour crisis/on-call coverage by a physician or psychiatric nurse practitioner;
3. Availability of ordered pharmacologic agents within twenty-four (24) hours

4. Timely administration of prescribed medication in accordance with the MS Nursing Practice Act;
5. Access to medical services for preexisting conditions that require ongoing medical attention (e.g. high blood pressure, diabetes, etc.);
6. Immediate availability of a limited supply of injectable psychotropic medications, medications for urgent management of non-life threatening medical conditions (e.g., insulin, albuterol inhalers and medications used for withdrawal management);
7. Ongoing assessment and monitoring for persons with mental illness or substance abuse considered by medical or psychiatric staff to be at high risk;
8. Training/certification of staff in prevention/management of aggressive behavior program; and
9. Procedures for maintenance of clinical records, including:
   (a) Documentation of information by professional staff across disciplines;
   (b) Documentation of physician's orders;
   (c) Basic personal data and information that ensures rapid emergency contact, if needed.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 35.6 ~~38.6~~ Dignity of Individuals

B. In order to ensure the dignity and rights of individuals being held in a facility for reasons of psychiatric crisis or civil commitment, reasonable access to the following must be allowed:

1. Protection and advocacy services/information;
   (a) Disability Rights MS 800-772-4057;
   (b) Dept. of Mental Health 877-210-8513;
2. Chaplain services;
3. Telephone contact; and
4. Visits with family members.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 36 ~~39~~: Consultation and Education Services

Rule 36.1 ~~39.1~~ Written Plan

B. The provider of the Consultation and Education Services must develop and implement a written plan to provide these services. The plan must include a range of activities for:

1. Developing and coordinating effective mental health education, consultation, and public information programs; and
2. Increasing the community awareness of mental health related issues.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 36.2 ~~39.2~~ Target Populations

B. The Consultation and Education Services must be designed to specifically meet the needs of the target populations of:

1. Children and youth;
2. Elderly persons;
3. Individuals with serious mental illness;
4. Individuals with intellectual/developmental disabilities;
5. Individuals with a co-occurring diagnosis (MH/~~A&D~~SUD/~~MR~~IDD);
6. Individuals with a mental illness who are homeless;
7. Military families and the military community; and
8. Other populations defined by the provider.

B. The provider must develop linkages with other health and social agencies that serve the target populations.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 37 ~~40~~: Prevention/Early Intervention for SED

Rule 37.1 ~~40.1~~ Service Design

C. Prevention/Early Intervention Services include preventive mental health programs targeting vulnerable at-risk groups with the intent to prevent the occurrence of mental and/or emotional problems and service programs designed to intervene as early as possible following the identification of a problem. Prevention and/or early intervention programs should be designed to target a specific group of children/youth and/or their families, such as children/youth who have been abused or neglected, teenage parents and their children, and young children and their parents. Children/youth identified as having a serious emotional disturbance and/or their families may also be targeted to receive specialized intervention early in the course of identification of the emotional disturbance.

D. A staff member must be designated to plan, coordinate and evaluate Prevention/Early Intervention Services.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 37.2 ~~40.2~~ Strategies

C. All Prevention/Early Intervention programs must maintain documentation that services include, but are not limited to, the following:

1. Informational activities designed to provide accurate and current information about emotional disturbance and mental illness in children/youth; or
2. Effective education activities, such as parent education, designed to assist individuals in developing or improving critical life skills and to enhance social competency thereby changing the conditions that reinforce inappropriate behavior; or
3. Consultation/education activities that are designed to include, but not be limited to, education and awareness activities to assist in the maintenance and/or improvement of services; or
4. Early Intervention services, including screening, assessment, referral, counseling, and/or crisis intervention services, designed to serve individuals identified as "high risk" and who are exhibiting signs of dysfunctional behaviors.

D. Development of linkages with other health and social service agencies, particularly with those serving children.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 37.3 ~~40.3~~ Documentation

D. Case records for persons provided individualized Primary Prevention or Early Intervention/Prevention Services (such as home-based individual education, parent or

sibling group education, screening/assessment or crisis intervention services) must be maintained with applicable forms in ~~accordance with~~ the DMH Record Guide.

E. Documentation of the provision of general or indirect presentations/activities on prevention and/or early intervention must include, at a minimum:

1. Topic and brief description of the presentation/activity
2. Group or individuals to whom the activity was provided
3. Date of activity
4. Number of participants
5. Name and title of presenter(s) of activity, with brief description of their qualifications/experience in the topic presented.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 38 ~~41~~: Family Support and Education Services

Rule 38.1 ~~41.1~~ Service Design

E. Family Support and Education Services~~, which~~ provide self-help and mutual support for families of children and youth with serious emotional disturbances ~~mental illness~~ or mental health challenges. ~~are based on the view that a person who is parenting or has parented a child experiencing emotional or behavioral health disorders can articulate the understanding of their experiences with another parent or family member.~~ This service increases the knowledge, skills and confidence of parents and family members in parenting their child/youth.

F. A staff member with documented training completed at a successful level in a DMH-approved program in family education and support for families of children/youth with behavioral/conduct or emotional disorders must be designated to coordinate family education and family support services.

G. The provider of Family Support and Education Services must maintain policies and procedures for offering and implementing appropriate family education and family support to families of children/youth with behavioral/conduct or emotional disorders that address, at a minimum, the following:

1. Description of individuals targeted to receive Family Support and Education Services;
2. Specific strategies to be used for outreach to the target population for Family Support and Education Services;
3. Description of qualifications and specialized training required for family support and education providers; and
4. Description of service components of Family Support and Education Services.

H. A variety of family education activities appropriate for families of children/youth with behavioral/conduct or emotional disorders must be made available through pamphlets, brochures, workshops, social activities, or other appropriate meetings or methods/types of presentations with an individual family or groups of families.

E. These activities must be documented and address one or more of the following or other DMH pre-approved topics:

1. Identified methods and approaches commonly used to identify children/youth with behavioral, conduct or emotional disorders;
2. Development of a family action plan;
3. Prevalent treatment modalities;
4. Common medications;

5. Child development;
6. Problem-solving;
7. Effective communication;
8. Identifying and utilizing community resources;
9. Parent/professional collaboration;
10. Overview of a collaborative service network;
11. Consultation and education; and,
12. Pre-evaluation screening for civil commitment for ages fourteen (14) and up.

F. Documentation of the activity and/or group must include, at a minimum:

1. Topic and brief description of the presentation/activity or group
2. Group or individuals to whom the activity was provided
3. Date of activity
4. Number of participants
5. Name and title of presenter(s) or facilitator(s), with brief description of their qualifications/experience in the topic presented.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 39 ~~42~~: Making A Plan (MAP) Teams

Rule 39.1 ~~42.1~~ Service Design

D. Making a Plan (MAP) Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders and dually diagnosed with serious emotional/behavioral disorders and an intellectual disability or SED and alcohol/drug abuse; who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

E. Each MAP Team must be comprised of at least one child behavioral health representative employed by the CMHC who has a Bachelor's degree. In addition, there must be at least one representative from each of the following:

1. Each local school district in a county served by a MAP Team
2. County Family and Children's Services Division of the State Department of Human Services
3. County or Regional Youth Services Division of the State Department of Human Services
4. County or Regional Office of the State Department of Rehabilitation Services
5. County or Regional Office of the Mississippi State Department of Health
6. Parent or family member with a child who has experienced an emotional and/or behavioral disturbance
7. Additional members may be added to each team, to include significant community-level stakeholders with resources that can benefit the children with serious emotional disturbance.

F. The Community Mental Health Center (DMH-C) must maintain a current written interagency agreement with agencies participating in the MAP Team.

~~G. A CMHC Master's level therapist must participate in the Regional A-Team Meetings that are held by the Mississippi Department of Human Services (MDHS) in their catchment areas. *(Please refer to the DMH Division of Children and Youth Services Directory for definition and locations of* MDHS Regional A-Teams.)~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 39.2 ~~42.2~~ Access to MAP Teams

F. All providers certified as Community Mental Health Centers (DMH-C) must make available or participate in at least two (2) standing MAP Teams in each CMHC region.

G. All providers certified as DMH/C must have a written plan that describes how each county in their catchment area will develop or have access to a MAP Team. The plan must include time lines for ensuring each county has access to or has developed a MAP Team. Additionally, the plan must be available for DMH Review.

H. Before referring a child/youth to a Psychiatric Residential Treatment Facility (PRTF), the CMHC must first have the local MAP Team review the situation to ensure all available resources and service options have been utilized. This does not include those children/youth who are in immediate need of acute hospitalization due to suicidal or homicidal ideations.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

~~Part 2: Chapter 43: Fetal Alcohol Spectrum Disorders (FASD) Screening, Diagnosis, and Treatment Services~~

~~Rule 43.1 FASD Definition~~

~~Fetal alcohol spectrum disorders (FASD) is an umbrella term describing the range of effects that can occur in an individual whose mother drank alcohol during pregnancy. These effects may include physical, mental, behavioral, and/or learning disabilities with possible lifelong implications. Behavioral or cognitive problems may include intellectual disability, learning disabilities, attention deficits, hyperactivity, poor impulse control, and social, language, and memory deficits. Early identification and diagnosis of children with an FASD can help ensure appropriate treatment which in turn will help reduce the occurrence and impact of these secondary disabilities.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 43.2 Screening~~

~~A. Children ages birth to age eighteen (18) must be screened within six (6) months of Intake to determine if there is a need for a Fetal Alcohol Spectrum Disorders (FASD) diagnostic evaluation. Youth ages eighteen (18) to twenty-four (24) may be screened for an FASD if the provider has reason to believe that there was prenatal alcohol exposure.~~

~~B. The FASD Screening Tool will be provided by the Division of Children and Youth Services (see the DMH Record Guide). The screening may be conducted by a community support specialist, a therapist, or other children's mental health professional.~~

~~C. Results of the FASD screening must be reported at least monthly to the Division of Children and Youth Services using the FASD Data Tool found in the DMH Record Guide.~~

~~D. Results of the FASD screening and FASD diagnostic evaluations, if indicated, must be reflected in the child's Individual Service Plan and/or Community Support Activity Plan. If a child receives a fetal alcohol-related diagnosis, it should be recorded on the appropriate diagnostic Axis.~~

~~H. If a child's initial FASD screening result is negative and if additional information regarding maternal alcohol history is obtained that might change the results of the initial FASD screen from negative to positive for possible prenatal alcohol exposure, the result of the initial screening must be revised on the FASD Screening Form to reflect this change and a diagnostic evaluation must be sought.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 43.3 Diagnosis~~

~~A. With consent obtained from the parent/legal representative, children ages birth to seven (7) who receive a positive FASD screen should be referred to the Child Development Clinic at the University of Mississippi Medical Center or other multi-disciplinary children's clinic qualified to diagnose FASD for a diagnostic evaluation. Children screened positive for risk who are older than age seven (7) may be referred to a multi-disciplinary FASD diagnostic provider.~~

~~B. With consent obtained from the parent/legal representative, historical and treatment information should be exchanged with the Child Development Clinic or other multi-disciplinary children's clinic to assist with completion of the diagnostic evaluation.~~

~~C. A copy of the full diagnostic report must be placed in the child's record.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 43.4 Treatment~~

~~A. Treatments and interventions recommended by the FASD multi-disciplinary diagnostic team must be either provided or facilitated by the service provider. Referral to the local MAP Team should be made when appropriate.~~

~~B. Because children with an FASD often do not respond to traditional mental health services and/or treatments, children's mental health services and other behavioral health services may need to be modified in order to be more effective. FASD services or service modifications must be documented in the child's record.~~

~~C. Mental health treatment options for children with an FASD diagnosis must be selected from those Best Practices, Evidence Based Treatments or Promising Practices approved by DMH.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 40 ~~44~~: Respite Care for Children/Youth with an SED

Rule 40.1 ~~44.1~~ Service Design

A. Respite is ~~a~~ short-term planned relief care in the home or community for children/youth with serious emotional/behavioral disturbances or mental health challenges. This service offers time out for caregivers and children/youth, helping family members to cope with their responsibilities, to rest and regroup, facilitate stability, and feel less isolated from the community, family and friends. The provision of services is community-based, culturally competent, and child-centered with the family participating in all decision-making.

B. An individual with, at a minimum, a Master's degree in a mental health or closely related field, must be designated to plan and supervise respite services. The Supervisor can also have administrative or other supervisory responsibility for other services or programs.

C. Providers of Respite Services must maintain documentation of linkages with other health and social service agencies, particularly those that serve children/youth.

D. Respite Services must be available a minimum of once per month for up to the number of hours per month determined necessary, based on individual needs of the child/youth and his or her family.

E. The program must implement behavior management approaches that utilize positive reinforcement of appropriate behaviors. Documentation must be maintained that respite service providers have received all required training for new and/or existing employees/volunteers specified in Part 2: Chapter 12.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 40.2 ~~44.2~~ Policies and Procedures

In addition to the requirements in Part 2: Chapter 8, the written policy and procedure manual for the operation of Respite Services must also include the following areas:

A. Written description of responsibilities of Respite Service providers;
B. Written description of specialized training required for Respite Service providers; and
C. Description of procedures for developing and implementing behavior change/management programs for children/youth served on a regular basis.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 40.3 ~~44.3~~ Information to Parents/Legal Representatives

At the time of the initial interview, the provider of Respite Services must document that the following information has been provided in writing and explained in a manner easily understood

to parent(s), legal representative(s) and youth being served in the program, as part of information provided to youth, parent(s)/legal representative(s) prior to or upon provision of Respite Services:

A. Employment criteria/credentials of the potential Respite Service provider;
B. Respite program's policy concerning behavior management. (The program must be very specific in its description pertaining to behavior management.);
C. Signed confidentiality statement; and
D. Service Agreement between the caregiver, the individual staff provider, and the provider agency clearly stating what entity agrees to do while services are being provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 41 ~~45~~: Wraparound Facilitation

Rule 41.1 ~~45.1~~ Service Design

G. Wraparound Facilitation is the creation and facilitation of a child and family team for the purpose of developing a single plan of care to address the needs of youth with complex mental health challenges and their families.

H. Wraparound facilitation is intended to serve:

6. Children/youth with serious mental health challenges who exceed the resources of a single agency or service provider
7. Children/youth who experience multiple acute hospital stays
8. Children/youth who are at risk of out-of-home placement or have been recommended for residential care
9. Children/youth who have had interruptions in the delivery of services across a variety of agencies due to frequent moves
10. Children/youth who have experienced failure to show improvement due to lack of previous coordination by agencies providing care, or reasons unknown can also be served through wraparound facilitation.

I. Child and family team membership must include:

6. The wraparound facilitator;
7. The child's service providers, any involved child serving agency representatives and other formal supports, as appropriate;
8. The caregiver/guardian;
9. Other family or community members serving as informal supports, as appropriate; and
10. Identified youth, if age nine (9) or above, unless there are clear clinical indications this would be detrimental. Such reasons must be documented clearly throughout the record.

J. The Wraparound family and child team must have access to MAP Team flexible funds if needed for non-traditional supports and resources to carry out the Wraparound Individualized Support Plan.

K. The child/youth accessing funds for non-traditional supports will not need to be reviewed by the MAP Team to access these funds.

L. The Wraparound Facilitator will document expenses in the Plan and the MAP Team Coordinator will include the child/youth in the quarterly reports sent to DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 41.2 ~~45.2~~ Wraparound Activities

B. Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice.

B. Activities include:

16. Engaging the family;
17. Assembling the child and family team;
18. Facilitating a child and family team meeting at a minimum every thirty (30) days;
19. Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting;
20. Working with the team in identifying providers of services and other community resources to meet family and youth needs;
21. Making necessary referrals for youth;
22. Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings;
23. Presenting plan of care for approval by the family and team;
24. Providing copies of the plan of care to the entire team including the youth and family/guardian;
25. Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes;
26. Maintaining communication between all child and family team members;
27. Monitoring the progress toward needs met and whether or not the referral behaviors are decreasing;
28. Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs;
29. Educating new team members about the wraparound process; and
30. Maintaining team cohesiveness.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 42 ~~46~~: Peer Support Services

Rule 42.1 ~~46.1~~ Service Design

H. Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and substance use disorders services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms, substance use issues and challenges associated with various disabilities while directing their own recovery. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery. Peer Support is a helping relationship between peers and/or family members that is directed toward the achievement of specific goals defined by the individual. It may also be provided as a family partner role.

I. Providers of Peer Support Services must develop and implement a service provision plan that addresses the following:

8. The population to be served, including the expected number of individuals to be served, diagnoses, age and any specialization.
9. The types of services and activities offered, particular peer supports utilized, including whether services will be provided on an individual or group basis, type of intervention(s) practiced, typical program day or service and expected outcomes.
10. Program capacity, including staffing patterns, staff to consumer ratios, staff qualifications and cultural composition reflective of population, and plan for deployment of staff to accommodate unplanned staff absences to maintain staff to consumer ratios.
11. A description of how the mental health/substance use disorder professional will maintain clinical oversight of Peer Support Services, which includes ensuring that services and supervision are provided consistently with DMH requirements.
12. A description of how Peer Specialists within the agency will be given opportunities to meet with or otherwise receive support from other Peer Specialists both within and outside the agency.
13. A description of how the Certified Peer Specialist and Certified Peer Specialist Supervisor will participate in and coordinate with treatment teams at the request of a consumer and the procedure for requesting team meetings.
14. A description of how the provider will recruit and retain Certified Peer Support Specialists.

J. Peer Support Services are voluntary. Individuals and/or their guardians must be offered this service when indicated as necessary to promote recovery and resiliency by a mental health professional and/or physician.

D. Peer Support Services are provided one on one (1 on 1) or in groups. When rendered in groups, the ratio of staff to individuals receiving the service should be, at a minimum, one (1) staff member to eight (8) individuals.

E. Peer Support Services must be included in and coordinated with the individual's Individual Service Plan. A specific planned frequency for service should be identified by the physician and/or mental health professional who believes the individual would benefit from this recovery/resiliency support.

F. Certified Peer Support Specialists must provide documentation of successful completion of at least one of the DMH recognized peer training programs, that is designed to increase the knowledge of the Certified Peer Support Specialist about the population he/she will be supporting.

G. ~~F.~~ Peer Support Services must be supervised by a mental health professional who has completed the DMH required peer supervisory training.

H. ~~G.~~ Certified Peer Specialists may be employed as part-time or full-time staff depending on agency capacity, the needs of the community being served, and the preferences of the employee.

I. ~~H.~~ Providers are encouraged to employ more than one Certified Peer Specialist within an agency and to employ Certified Peer Specialists who reflect the cultural, ethnic, and public mental health service experiences of the people with whom they will work.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 42.2 ~~46.2~~ Activities

B. Peer Support Services include a wide range of structured activities that are provided face to face to assist individuals in their recovery/resiliency process. Activities should support goals of the individual's documented Individual Service Plan and/or Wellness Recovery Action Plan (WRAP) that may include the following:

9. Individual wellness and recovery/resiliency
10. Education and employment
11. Crisis Support
12. Housing and community living
13. Social networking
14. Development of natural supports
15. Self-determination
16. Self-advocacy

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 43 ~~47~~: Early Intervention and Child Development Services for Children with a Developmental Delay

Rule 43.1 ~~47.1~~ All Early Intervention and Child Development Services

L. Early Intervention and Child Development Services are designed to support families in providing learning opportunities for their child within the activities, routines, and events of everyday life by providing information, materials, and supports relevant to their identified needs. Early Intervention Services are provided in the child's natural environment. Child Development Services provide center based programs which promote the developmental growth of children in cognitive, physical, social, emotional, communication, and adaptive functioning areas.

M. The program must maintain documentation of at least quarterly public awareness activities that are broad, ongoing, and responsive to rural areas. The program must use a variety of methods to inform the public of available services.

N. The program must conduct and provide documentation of annual Child Find activities in the community to assist in the early identification of children with developmental disabilities or children who are at risk of developing developmental disabilities.

O. Families of children under three (3) years of age must be informed about the First Steps Early Intervention Program (FSEIP) unless they are referred from FSEIP.

P. Within thirty (30) days of admission, a dated photograph of the child must be taken and placed in his/her record. The photo must be updated annually for children birth to three (3) years.

Q. Program staff must participate in review, revisions, and annual updates of each child's Individual Family Service Plan (IFSP).

R. The program must have goals and objectives for at least quarterly parental involvement and education which is based on the expressed interests/needs of the parents as ascertained from a parental interest/needs survey.

S. The program must document the provision of information given to parents about developmental disabilities, developmental patterns, and other information pertinent to their child and which is understandable to the parents.

T. The program must assist the family in achieving a smooth transition to educational services or another environment by:

4. Discussing with parents future services/supports and other matters related to the child's transition to other services/environments;
5. Supporting the family in preparing the child for changes in service delivery; and

6. Participate in IFSP meetings to discuss transition activities as requested through written prior notice from First Steps.

U. At a minimum, the setting for Early Intervention Services must:

1. Provide equipment that is of an appropriate size and nature for the child using it;
2. Provide materials, toys, and equipment to stimulate, motivate, and entice children to explore the world around them; and
3. Procure special adaptive equipment for children with severe physical disabilities, when required.

V. Program site must maintain and post a current Mississippi State Department of Health inspection as required by law and meet all other applicable local/state/federal laws and regulations.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 43.2 ~~47.2~~ Programs Working with First Steps Early Intervention Programs (FSEIP)

E. Early Intervention Programs must provide services and supports which enhance the family's capacity to support their child's development.

B. The program must document the provision of services and progress toward outcomes as stated on the child's Individualized Family Service Plan (IFSP).

C. Program staff must report to the Service Coordinator in writing the actual day services started within five (5) calendar days after admission into the program.

K. The program must update assessments to determine any changes in the child's skills in the areas of cognition, communication, fine and gross motor, adaptive, and socialization to submit to the FSEIP Service Coordinator for utilization in annual evaluation of the Individualized Family Service Plan.

E. The non-primary service provider must send updated assessment and other needed information to the primary service provider ninety (90) days before the child exits the service. The primary service provider must complete the Outcome Rating Scale within sixty (60) days prior to the child's exit from First Steps Early Intervention.

F. Children must be served in natural environments unless the provision of Early Intervention Services as indicated on the IFSP cannot be achieved satisfactorily in a natural environment.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 43.3 ~~47.3~~ Child Development Services

B. Within thirty (30) days of admission and at least annually thereafter, conduct an educational assessment to determine a child's skills in the areas of cognition, communication, fine and gross motor, adaptive, and socialization for utilization in the development of an individualized service plan.

B. Provide or access services as indicated in a child's evaluation reports from a licensed speech-language pathologist (SLP), qualified teacher, registered occupational therapist (OT), registered physical therapist (PT), and/or other qualified personnel.

C. Document the following in the child's record regarding OT/PT/speech services:

1. Training provided by the OT/PT/speech therapists(s) for program staff
2. Any special techniques needed for the safe handling of a child
3. How program staff might implement any recommended special procedures/techniques into the child's educational program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 44 ~~48~~: ID/DD Waiver Support Coordination Services

Rule 44.1 ~~48.1~~ General

F. Support Coordination is responsible for coordinating and monitoring all services an individual on the ID/DD Waiver receives, regardless of funding source, to ensure services are adequate, appropriate, meet individual needs, and ensure the individual's health and welfare needs are met and addressed.

~~G. The Support Coordination Director must maintain a list of individuals who have been evaluated and determined eligible for the ID/DD Waiver but who cannot be enrolled in the program at the time of eligibility determination.~~

C. The maximum caseload for a support coordinator is thirty ~~five~~ two (3~~5~~ 2) waiver participants.

H. Support Coordinators cannot supervise or provide any other ID/DD Waiver service.

I. Support Coordination Services must be distinctly separate from other ID/DD Waiver service(s) an agency provides.

L. ~~Support Coordinators are responsible for maintaining electronic files as required by BIDD.~~

F. Support Coordinators must adhere to the requirements in the ID/DD Waiver Support Coordination Manual.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 44.2 ~~48.2~~ Support Coordination Activities

G. Coordinating and facilitating the development of the Plan of Services and Supports through the person-centered planning process.

H. Revising/updating each individual's Plan of Services and Supports at least annually or when changes in the individual's circumstances occur or when requests are made by the individual/legal guardian.

I. Informing individuals/legal guardians about all ID/DD Waiver, and non-waiver services.

J. Informing individuals/legal guardians about certified providers for the services on his/her approved Plan of Services and Supports initially, annually, if he/she becomes dissatisfied with the current provider, when a new provider/site is certified, or if a provider's certification status is affected.

K. Assisting the individual/legal guardian with meeting/interviewing agency representatives and/or arranging tours of service sites until the individual chooses a provider.

L. Support Coordinators are responsible for entering required information in Medicaid's LTSS System.

~~G. Sending copies of the Plan of Services and Supports and Service Authorizations to all appropriate providers upon receipt of approval/denial from BIDD.~~

G. ~~H.~~ Notifying each individual of ~~approval/denial for~~:

1. Initial enrollment
2. Approval/denial of requests for additional services
3. Approval/denial of requests for increases in services
4. Approval for requests for recertification for services ~~of ICF/IID level of care~~
5. Approval for requests for readmission.
6. Reduction in service(s)
7. Termination of service(s)

~~I. Notifying each individual of:~~

~~1. Approval of service (s)~~
~~2. Reduction in service(s)~~
~~3. Termination of service(s)~~
~~4. Discharge from the ID/DD Waiver~~

H. ~~J.~~ Informing and providing the individual/legal representative with the procedures for appealing the denial, reduction, or termination of ID/DD Waiver services.

I. ~~K.~~ Educating individuals, legal guardians and families on individual's rights and the procedures for reporting instances of abuse, neglect and exploitation.

J. ~~L.~~ Performing all necessary functions for the individual's annual recertification of ICF/IID level of care ~~including completing the Level of Care Reevaluation Tool and Risk Assessment Tool.~~

K. ~~M.~~ Ongoing monitoring and assessment of the individual's Plan of Services and Supports that must include:

1. Information about the individual's health and welfare, including any changes in health status

2. Information about the individual's satisfaction with current service(s) and provider(s) (ID/DD Waiver and others)
3. Information addressing the need for any new services (ID/DD Waiver and others) based upon expressed needs or concerns or changing circumstances and actions taken to address the need (s)
4. Information addressing whether the amount/frequency of service(s) listed on the approved Plan of Services and Supports remains appropriate
5. Review of ~~individual~~ Activity Support Plans developed by agencies which provide ID/DD Waiver services to the individual
6. Ensuring all services an individual receives, regardless of funding source, are coordinated to maximize the benefit and outcome for the individual
7. Follow-up activities regarding issues/needs identified during monthly or quarterly contacts or those reported by providers.

L. ~~N.~~ Monitoring service provision/implementation monthly through onsite face-to-face visits, telephone contacts and review of the monthly utilization. ~~reports and review of quarterly provider reports.~~

M. ~~O.~~ Addressing issues related to an individual's Plan of Services and Supports with ~~the~~ his/her provider(s). If a provider is not responsive, the Support Coordinator is responsible for reporting the issue as a grievance through DMH's established grievance reporting procedures through the Office of Consumer Support.

N. ~~P.~~ Speaking with individuals and/or their legal guardian at least ~~two~~ one (~~2~~ 1) time~~s~~ per month or more frequently as determined by the Plan of Services and Supports or seeing the individual during a face-to-face contact. The following items must be addressed:

8. Determine if needed supports and services in the Plan of Services and Supports have been provided
9. Review implementation of ~~strategies, guidelines, and action~~ Activity Support Plans to ensure specified ~~need, preferences, and desired~~ outcomes are being met
10. Review the individual's progress and accomplishments
11. Review the individual's satisfaction with services and providers
12. Identify any changes to the individual's needs, preferences, desired outcomes, or health status
13. Identify the need to change the amount or type of supports and services or to access new waiver or non-waiver services
14. Identify the need to update the Plan of Services and Supports

O. ~~Q.~~ Conducting face-to-face visits with each individual and legal guardian at least once every three (3) months, rotating service settings and talking to staff. For people who receive only day services, at least one (1) visit per year must take place in the person's home.

~~R. Providing follow-up on needs/issues reported by the individual/legal guardian, providers or any other source.~~

~~S. Requiring Master's level staff to review all initial and re-evaluations of level of care before submission to BIDD.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 45 ~~49~~: ID/DD Waiver In-Home ~~Nursing~~ Respite Services

Rule 45.1 ~~49.1~~ General

~~A. In-Home Nursing Respite is provided by a registered or licensed practical nurse in accordance with the Mississippi Nursing Practice Act and other applicable laws and regulations.~~

B. ~~B.~~ In-Home ~~Nursing~~ Respite provides temporary, periodic relief to those persons normally providing care for the eligible individual. In-Home ~~Nursing~~ Respite staff provides all the necessary care the usual caregiver would provide during the same time period.

~~C. In-Home Nursing Respite may also be provided when the usual caregiver is unexpectedly absent or incapacitated due to hospitalization, illness, injury or upon their death, depending on individual circumstances.~~

C. ~~D.~~ In-Home ~~Nursing~~ Respite is only available to individuals living in a family home and is not permitted for individuals living independently, either with or without a roommate.

~~E. Individuals must have a statement from his/her physician/nurse practitioner stating:~~

~~1. The treatment procedure(s) the individual needs in order to justify the need for a nurse in the absence of the primary caregiver;~~

~~2. How long the treatment(s) and/or procedure(s) are expected to continue.~~

F. ~~F.~~ In-Home ~~Nursing~~ Respite is not available for people who receive Supported Living, Supervised Living, Shared Supported Living, Host Home services, or who live in any other type of staffed residence.

G. ~~G.~~ In-Home ~~Nursing~~ Respite is not available to individuals who are in the hospital, an ICF/IID, nursing home, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance.

H. ~~H.~~ In-Home ~~Nursing~~ Respite cannot be provided in the provider's residence.

~~I. Private Duty Nursing through EPSDT must be carefully coordinated with waiver services and be closely monitored to ensure EPSDT services are exhausted before waiver services are utilized.~~

~~J. In-Home Nursing Respite includes administration of medication and other treatments to the extent permitted by state law.~~

G. ~~K. Nurses~~ Staff may accompany individuals on short community outings but this cannot comprise the entirety of the service. Activities are to be based upon the outcomes identified in the PSS and implemented through the Activity Support Plan.

Allowable activities include:

6. Assistance with personal care needs such as bathing, dressing, toileting, grooming;
7. Assistance with eating and meal preparation for the person receiving services
8. Assistance with transferring and/or ambulation
9. Administration of medical treatments and/or procedures as prescribed by a physician (In-Home Nursing Respite only)
10. Leisure activities

Rule 45.2 Family Members as Providers of In-Home Respite

A. ~~L. In-Home Nursing Respite cannot be provided by family members~~. The following types of family members are excluded from being providers of In-Home Respite:
   1. Anyone who lives in the same home with the individual, regardless of relationship
   2. Those that are parents/step-parents of the individual receiving the services
   3. Those who are a spouse, relative or anyone else who is normally expected to provide care for the individual receiving the services

B. Providers seeking approval for a family member to serve as In-Home Respite staff, regardless of relationship or qualifications, must maintain the following documentation in each staffs' personnel record in addition to the requirements in Standard 11.2 and Chapter 12:

   4. Proof of address for the family member seeking to provide services. Proof of address is considered to be a copy of a lease, rental agreement, or utility bill that includes that person's name. If required documentation cannot be obtained, the family member seeking to provide services must provide a signed and notarized affidavit that includes his/her current address.
   5. Evidence the individual's ID/DD Waiver Support Coordinator has been notified the agency is seeking approval of a family member to provide HCS.
   6. Family members must receive the same training as non-family members and submit to background checks.

H. ~~M.~~ Individuals cannot be left unattended at any time during the provision of In-Home ~~Nursing~~ Respite Services.

I. Staff providing In-Home Respite cannot accompany individuals to medical appointments.

J. In-Home Respite services cannot be billed for while the person is receiving another Medicaid service, except Behavior Support.

K. Family members providing In Home Respite will only be authorized to provide a maximum of up to 172 hours per month (40 hours per week).

L. Providers must conduct drop-in, unannounced quality assurance visits during the time the approved family member is providing services. These visits must occur at least two (2)

times per year. Documentation of these visits must be maintained in the staff's personnel record. Documentation must include:

1. Observation of the family member's interactions with the person receiving services
2. Review of the Plan of Services and Supports and Service Notes to determine if outcomes are being met and
3. Review of utilization to determine if contents of Service Notes support the amount of service provided.

Rule 45.3 In-Home Nursing Respite

G. The Standards in Rule 45.1 also apply.

H. In-Home Nursing Respite is provided by a registered or licensed practical nurse. He/she must provide nursing services in accordance with the Mississippi Nursing Practice Act and other applicable laws and regulations.

I. In-Home Nursing Respite is provided for persons who require skilled nursing services, as prescribed by a physician, in the absence of the primary caregiver. The need for administration of medications alone is not a justification for receiving In-Home Nursing Respite services. Caregivers are required to make other arrangements for the administration of medications if they will be absent during the time the medication is normally given.

J. Individuals must have a statement from their physician/nurse practitioner stating:

4. The treatment(s) and/or procedure(s) the individual needs in order to justify the need for a nurse in the absence of the primary caregiver; and
5. The amount of time needed to administer the treatment(s)and/or/procedure(s); and
6. How long the treatment(s) and/or procedure(s) are expected to continues

K. Private Duty Nursing services through EPSDT must be exhausted before waiver services are utilized.

L. In-Home Nursing Respite cannot be provided by family members.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 46 ~~50~~ : ID/DD Waiver Behavior Support ~~and Intervention~~ Services

Rule 46.1 ~~50.1~~ General

A. Behavior Support provides systematic behavior assessment, Behavior Support Plan development, consultation, restructuring of the environment and training for individuals whose maladaptive behaviors are significantly disrupting their progress in ~~habilitation~~ learning, self-direction or community ~~integration~~ participation and/or are threatening to require movement to a more restrictive setting. This service also includes consultation and training provided to families and staff working with the individual. The desired outcome of the service is long-term behavior change.

B. If at any time an individual's needs exceed the scope of the services provided through Behavior Support~~s~~, the individual will be ~~refereed~~ referred to other appropriate services to meet his/her needs.

E. This service is not restricted by the age of the individual; however, it may not replace educationally related services provided to individuals when the service is available under EPSDT, IDEA or other sources such as an IFSP through First Steps or ~~be~~ is otherwise available. All other sources must be exhausted before waiver services can be approved. This does not preclude a Behavior Consultant from observing an individual in his/her school setting, but direct intervention cannot be reimbursed when it takes place in a school setting.

F. Behavior Support must be provided on a one (1) staff to one (1) individual ratio.

E. Behavior Support ~~Consultation~~ Services consists of:

1. An on-site visit as part of a Functional Behavior Assessment to observe the individual to determine if the development of a Behavior Support Plan is warranted.
2. Informal training of staff and other caregivers regarding basic positive behavior support techniques that could be employed if it is determined that a Behavior Support Plan is not warranted based on the presenting behavior(s).
3. A Functional Behavior Assessment if consultation indicates a need based on the professional judgement of the Behavior Consultant.

~~F. Functional Behavior Assessments, including consultation, must be prior approved by the DMH Behavior Oversight Committee and consist of the elements specified in the DMH Record Guide.~~

F. ~~G.~~ Functional Behavioral Assessments are limited to every two (2) years, if needed, unless the individual changes providers or the Behavior Support Plan documents substantial changes to:

5. The individual's circumstances (living arrangements, school, caretakers)

6. The individual's skill development
7. Performance of previously established skills
8. Frequency, intensity or types of challenging behaviors

~~H. A Behavior Support Plan may only be developed and implemented after positive behavioral approaches recommended by DMH approved staff have been attempted and documented as required in the DMH Record Guide.~~

G. ~~I.~~ A medical evaluation for physical and/or medication issues must be conducted prior to completion of the Functional Behavior Assessment and before a Behavior Support Plan can be ~~developed~~ implemented.

H. ~~J.~~ Behavior Support Plans can only be developed by the person who conducted the Functional Behavior Assessment.

~~K. Implementation of all Behavior Support Plans must be prior approved by the DMH Behavior Services Oversight Team~~

W. ~~Continued implementation of a Behavior Support Plan must be reviewed by the Behavior Services Oversight Team~~

X. ~~The Behavior Support Plan must adhere to the requirements of the DMH Record Guide.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 46.2 ~~50.2~~ Role of the Behavior Consultants

B. Behavior Consultants must perform the following activities:

1. Provide consultation as part of the Functional Behavior Assessment
2. Conduct Functional Behavior Assessment
3. Develop Behavior Support Plan
4. Implement the Behavior Support Plan to the degree determined necessary
5. Train the Behavior Specialist and/or staff and other caregivers in the implementation of the Behavior Support Plan.
6. Monitor and review data submitted by the Behavior Specialist to determine progress toward successful implementation of the Behavior Support Plan
7. ~~Submit documentation to the Behavior Services Oversight Team regarding implementation of the Behavior Support Plan at intervals established in the Behavior Support Plan~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 46.3 ~~50.3~~ Role of the Behavior Specialist

A. Behavior Specialists are responsible for:

9. Participating in the development of the Behavior Support Plan with the Behavior Consultant
10. Implementing the Behavior Support Plan
11. Collecting and analyzing data for the effectiveness of the Behavior Support Plan
12. Monitoring fidelity of implementation of the Behavior Support Plan and reliability of the data
13. Adjusting or revising the strategies identified in the Behavior Support Plan as approved by the Behavior Consultant
14. Providing face-to-face training on the Behavior Support Plan and implementation strategies to staff and other caregivers. This shall include training for meals, hygiene, and/or community activities, and evenings and weekends noted in the_behavior support plan as particularly challenging.
15. Monitoring program staff and other caregivers on the implementation of the Behavior Support Plan
16. Submitting documentation to the Behavior Consultant as specified in the Behavior Support Plan which documents progress toward successful implementation of the Behavior Support Plan

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 46.4 ~~50.4~~ Provision of Behavior Support In Conjunction with Other Services

C. All providers must allow for implementation of the Behavior Support Plan in the service setting regardless of if another provider employs the Behavior Support staff. All appropriate staff must receive training from the Behavior Consultant and/or Behavior Intervention Specialist from the Behavior Support provider agency

D. Behavior Support can be provided simultaneously with other waiver services if the purpose is to:

1. Conduct a Functional Behavior Assessment;
2. Provide direct intervention; or
3. Provide training to staff/parents on implementing and maintaining the Behavior Support Plan.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 47 ~~51~~: ID/DD Waiver Home and Community Supports (HCS)

Rule 47.1 ~~51.1~~ General

K. Home and Community Supports (HCS) is for individuals who live in the family home and provides assistance with activities of daily living (ADLs) and instrumental activities of daily living (IADLs) such as bathing, toileting, transferring and ambulation, meal preparation (but not the cost of the meals themselves), assistance with eating and incidental household cleaning and laundry which are essential to the health, safety, and welfare of the individual. Other activities can include assistance with keeping appointments, use of natural supports and other typical community services available to all people, social activities and participation in leisure activities.

L. ~~Activities can include assistance with keeping appointments, use of natural supports and other typical community services available to all people, social interaction and participation in leisure activities.~~

M. Home and Community Supports may be shared by up to three (3) individuals who have a common direct service provider agency. Individuals may share HCS staff when agreed to by the participants and the health and welfare can be assured for each participant.

N. Home and Community Supports cannot be provided in a school setting or be used in lieu of school services or other available day services.

O. HCS is not available for individuals who receive Supported Living, Shared Supported Living, Supervised Living, Host Home services, or who live in any other type of staffed residence.

P. HCS is not available to individuals who are in the hospital, an ICF/IID, nursing home, or other type of rehabilitation facility that is billing Medicaid, Medicare, and/or private insurance.

Q. HCS providers are responsible for supervision and monitoring of the individual at all times during service provision whether in the individual's home, during transportation (if provided), and during community outings.

R. Home and Community Supports staff is not permitted to provide medical treatment as defined in the Mississippi Nursing Practice Act and Rules and Regulations.

S. HCS staff cannot accompany a minor on a medical visit without a parent/legal representative present.

T. Home and Community Supports cannot be provided in a provider's home or residence.

U. HCS staff may assist individuals with shopping needs and money management, but may not disburse funds on the part an individual without written authorization from the legal guardian, if applicable.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 47.2 ~~51.2~~ Family Members as Providers of HCS

B. The following types of family members are excluded from being providers of HCS:
   1. Anyone who lives in the same home with the individual, regardless of relationship
   2. Those that are parents/step-parents of the individual receiving the services
   3. Those who are a spouse, relative or anyone else who is normally expected to provide care for the individual receiving the services

~~E. Family members employed as staff to provide HCS must meet the qualifications and training requirements outlined in Part 2: Chapters 11 and 12.~~

B. ~~A.~~ Providers ~~seeking approval for~~ employing a family member to serve as HCS staff, regardless of relationship or qualifications, must maintain the following documentation in each staffs' personnel record in addition to the requirements in Standard 11.2 and Chapter 12: ~~get prior approval from the DMH Review Committee.~~

   3. Proof of address for the family member seeking to provide services. Proof of address is considered to be a copy of a lease, rental agreement, or utility bill that includes that person's name. If required documentation cannot be obtained, the family member seeking to provide services must provide a signed and notarized affidavit that includes his/her current address.
   4. Evidence the individual's ID/DD Waiver Support Coordinator has been notified the agency is seeking approval of a family member to provide HCS.

   ~~1. Each request for approval is considered on a case-by-case basis.~~
   ~~2. Each request must include a copy of the proposed staff's high school diploma or GED equivalent as well as documentation of reference checks.~~
   ~~3. If the proposed staff person does not meet the qualifications as outlined in Part 2: Chapter 11, a waiver of the DMH Operational Standard must be requested through the Bureau of Quality Management, Operations and Standards.~~

~~B. The following types of family members will not be considered for approval and are NOT allowed to provide HCS:~~

   ~~1. Anyone who lives in the same home with the individual, regardless of relationship~~
   ~~2. Those that are parents/step-parents of the individual receiving the services~~
   ~~3. Those who are a spouse, relative or anyone else who is normally expected to provide care for the individual receiving the services~~

F. Family members employed as staff to provide HCS must meet the qualifications and training requirements outlined in Part 2: Chapters 11 and 12.

G. Family members providing HCS ~~may~~ will only be authorized to provide a maximum of ~~up to~~ 172 hours per month (40 hours per week).

H. Providers must conduct drop-in, unannounced quality assurance visits during the time the approved family member is providing services. These visits must occur at least two (2) times per year. Documentation of these visits must be maintained in the staff's personnel record. Documentation must include:
   1. Observation of the family member's interactions with the person receiving services
   2. Review of Plan of Services and Supports and Service Notes to determine if outcomes are being met
   3. Review of utilization to determine if contents of Service Notes support the amount of service provided.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 48 ~~52~~ ID/DD Waiver Transition Services

Rule 48.1 ~~52.1~~ General

A. Transition Assistance is a one (1) time set up expense for individuals who transition from institutions (ICF/IID or Title XIX nursing home) to a less restrictive community living arrangement such as a house or apartment where they receive Supervised Living, Shared Supported Living, Supported Living services, or ~~a~~ Host Home Services ~~living arrangement~~ and who do not use services provided through the Bridge to Independence (Money Follows the Person) program.

B. To be eligible for transition assistance the following is necessary:

5. The individual cannot have another source to fund or attain the items or support
6. The individual cannot be transitioning from a setting where these items were provided
7. The individual must be moving to a residence where these items are not normally furnished.
8. The individual's ICF/IID or nursing facility stay is not acute or for rehabilitative purposes.

C. Items bought using these funds are for individual use and are to be property of the individual if an individual moves from a residence owned or leased by a provider.

D. There is a one-time, life time maximum of $800 per individual.

G. Service expenditures must be on the individual's approved Plan of Services and Supports.

H. Transition Assistance, if approved on the PSS, must be provided by the community living (Supervised, Shared Supported Living, Supported Living or Host Home) provider in order to aid in transition.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 48.2 ~~52.2~~ Expenditures for Transition Assistance

G. Examples of expenses that may be covered as Transition Assistance are:

10. Transporting furniture and personal possessions to the new living arrangement
11. Essential furnishing expenses required to occupy and use a community domicile
12. Linens and towels
13. Cleaning supplies
14. Security deposits that are required to obtain a lease on an apartment or home that does not constitute paying for housing rent
15. Utility set-up fees or deposits for utility or service access (e.g. telephone, water, electricity, heating, trash removal)
16. Initial stocking of the pantry with basic food items

17. Health and safety assurances such as pest eradication, allergen control or one-time cleaning prior to moving
18. Essential furnishings include items for an individual to establish his or her basic living arrangements such as a bed, table, chairs, window blinds, eating utensils, and food preparation items.

H. Transition Assistance services shall not include monthly rental or mortgage expenses, regular utility charges, and/or household appliances or recreational electronics such as DVD players, game systems, or computers.

I. At the Person Centered Planning meeting, the individual and/or legal guardian, and the rest of the team agree upon the basic types of items to be purchased.

J. The provider makes purchases and arranges to store the item(s) until the individual is ready to move into his/her new home.

K. After the individual moves, the provider submits a claim to Medicaid for the dollar amount of the items, up to the approved maximum reimbursement rate. If the total amount of purchases exceeds the approved maximum reimbursement rate, the provider will only be paid up to that amount~~.~~

L. The provider must maintain receipts for all items purchased in the individual's record and send copies to the ID/DD Waiver Support Coordinator.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 49 ~~53~~: All Substance ~~Abuse~~ Use Disorders Prevention and ~~Rehabilitation/~~Treatment Services

Rule 49.1 ~~53.1~~ General

C. All DMH ~~funded~~ certified service providers of an ~~alcohol~~ substance use ~~and other drug~~ disorders services must submit the Mississippi Substance Abuse Management Information System (MSAMIS) report to the DMH~~, Bureau of Alcohol and Drug Abuse Central Data Repository~~ by the tenth (10th) working day of the month following the reporting period.

D. The Provider must have written policies and procedures for the ~~discharge of an individual from a program including, but not limited to the~~ following:

1. Successful completion of treatment
~~2. Noncompliance with program rules and regulations~~
2. Transfer of individual to another program
3. ~~Instances in which the individual leaves a program (self-declared discharge) against the advice/approval of program director or designee.~~
9. Program re-entry after any disruption of services
10. ~~Staff~~ Individual initiated discharges ~~prior to the individual's successful~~ without completion: ~~of treatment is a last resort. Other options must be utilized when possible~~.
    (a) When individuals choose to disregard program rules and regulations after facility has documented all interventions clinically available to staff.
    (b) When individuals willfully choose to leave the program.
11. Staff initiated discharges ~~prior to the individual's successful~~ without completion ~~of treatment take place only after a staffing has taken place with the~~ (last resort):
    (a) Standard protocol of interventions utilized before discharge is initiated.
    (b) The required protocol for treatment team ~~in order~~ meeting including:
        (1) Required staff present
        (2) Requirement for review of all interventions used prior to ~~make~~ this staffing
        (3) How the ~~determination about~~ treatment team makes the discharge decision
~~7. Regardless of the reason for discharge, individuals must be referred to other service options based on their needs.~~
        (4) In order to help DMH Referral planning practices
12. Acceptance and accommodation of individuals entering treatment services utilizing medication assisted treatment (MAT)
13. Discharge from services after no therapeutic contact within the last ninety (90) days

D. To assist with appropriate referrals and placement ~~of individuals in need of service~~, all residential programs ~~certified by DMH must notify the DMH Office of Consumer Support immediately, but not to exceed seven (7) days, by fax or email:~~ must report to

DMH when the census of the program exceeds ~~Each time they reach~~ 90% capacity~~;~~ and When they subsequently fall when the census drops below 90% capacity. Report should be submitted to the Office of Consumer Support by fax or the Bureau of Alcohol and Drug Services by email within 24 hours of crossing the 90% threshold.

G. For programs classified as a state or federal institution or correctional facility that are certified by CARF, The Joint Commission, the American Corrections Association or other certification body approved by the DMH, DMH ~~will~~ may accept those certifications in lieu of the Health and Safety Operational Standards with the exception of standards related to clinical program operation and personnel requirements. Programs must be in good standing with the applicable certification body in order for approval to be granted.

H. The Joint Commission (TJC) accredited substance ~~abuse~~ use disorder treatment service providers (not funded by DMH) seeking DMH certification must submit documentation of TJC accreditation in the specific substance ~~abuse~~ use disorder area(s) that corresponds (not to include DUI) with the substance ~~abuse~~ use disorder service area(s) included in the DMH Operational Standards. The DMH will determine if the documentation is sufficient to support certification in the specific substance ~~abuse~~ use disorder services areas.

I. All programs must have a physical environment which provides designated space for privacy of individual and group counseling sessions.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.2 ~~53.2~~ HIV and Tuberculosis (TB) Risk Assessment and Testing

D. All providers must provide and document that all individuals receiving substance ~~abuse~~ use disorder treatment receive a risk assessment for HIV at the time of intake. For individuals determined to be high risk by the HIV assessment, testing options are determined by level of care and must be provided as follows:

4. Outpatient Services: Individuals must be offered on-site HIV Rapid testing by the organization or informed of available HIV testing resources available within the community.
5. Primary Residential Services: Individuals must be offered and encouraged to participate in onsite HIV Rapid Testing. If HIV Rapid Testing is not immediately available, then testing must be offered using other methodology on site or the individual must be transported to a testing site in the community only until such time as a Rapid Testing Program can be implemented.
6. Transitional Residential and Recovery Support Services: Individuals must be offered and encouraged to participate in onsite HIV Rapid Testing unless the program can provide documentation that the individual received the risk assessment and was offered testing ~~during primary substance abuse treatment.~~ within the last 6 months. If testing was refused, the facility should encourage further testing. If HIV Rapid Testing is not immediately available, then testing must be offered using other

methodology on site or the individual must be transported to a testing site in the community only until such time as a Rapid Testing Program can be implemented.

E. All programs must have and follow written policies and procedures for ensuring maximum participation from individuals in HIV testing to include:

4. Standardized procedures for conducting an HIV Risk Assessment.
5. Utilization of an "opt-out" methodology for documenting individuals' ~~consent~~ who decline to be tested.
6. Standardized protocol for explaining the benefits of testing.

F. All programs offering HIV Early Intervention Testing should provide at a minimum:

4. A minimum of 30 minutes up to one hour of pre-test counseling which must include a risk assessment if one hasn't been previously conducted.
5. Offer appropriate post-test counseling as needed. If preliminary testing is reactive (positive) then a minimum of 60 minutes of posttest counseling is required.
6. All programs providing onsite testing must have the following

(e) A Clinical Laboratory Improvements Amendments (CLIA) Waiver
(f) Relevant Staff training
(g) A written protocol for HIV testing
(h) Agreements with the State Department of Health or other relevant agency to obtain HIV test kits, where applicable

~~C. All programs receiving funds for Substance Abuse Block Grant (SABG) HIV Early Intervention Services (HIV-EIS) should at a minimum:~~

~~1. Onsite HIV Rapid Testing Services for programs offering any residential treatment services~~
~~2. One 30 minute pre-test counseling session which must include a risk assessment if one hasn't been previously conducted.~~
~~3. One 30 minute post-test counseling session for each individual that is tested for HIV. Note: 60 or more minutes of post-test counseling is limited to individuals who have a reactive HIV test ('preliminary positive test')~~
~~4. One hour of HIV Prevention Education for all individuals in treatment~~

~~2. Have evidence of the following for all residential treatment programs:~~

~~(i) A Clinical Laboratory Improvements Amendments (CLIA) Waiver~~
~~(j) Relevant Staff training~~
~~(k) A written protocol for HIV testing~~
~~(l) Agreements with the State Department of Health or other relevant agency to obtain HIV test kits, where applicable~~

D. Programs providing on-site testing ~~should~~ must have ~~in their~~ policies and procedures ~~a written protocol for administering HIV Testing. The Protocol should~~ that include but ~~is~~ are not limited to:

5. Standardized procedures for conducting an HIV test and delivering results
6. Standardized procedures for obtaining a confirmatory test in the case of a reactive "preliminary positive" test result
7. Documentation and standardized procedures for providing linkage to care
8. Quality control procedures to include:
   (a) Proper storage of HIV test kits and controls
   (b) Documentation of when and how often controls are run to verify test accuracy

E. All Primary and Transitional Residential providers must ~~provide and~~ document that all individuals ~~receiving primary substance abuse treatment receive~~ received a risk assessment for Tuberculosis (TB) at the time of intake. Any individual determined to be at high risk cannot be admitted into a treatment program until testing confirms the individual does not have TB.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.3 ~~53.3~~ Education Regarding HIV, TB, STDs

B. All providers must provide and document that all individuals receiving substance ~~abuse~~ use disorder treatment services receive a minimum of 1 hour of educational information concerning the following topics in a group and/or individual session:

1. HIV/AIDS
   (a) Modes of transmission;
   (b) Universal Precautions and other preventative measures against contracting/ spreading the virus; and
   (c) Current treatments and how to access them.
2. Tuberculosis (TB)
   (a) Modes of transmission; and
   (b) Current treatment resources and how to access them.
3. Sexually Transmitted Diseases (STDs)
   (a) Modes of transmission;
   (b) Precautions to take against contracting these diseases;
   (c) Progression of diseases; and
   (d) Current treatment resources and how to access them.
4. Hepatitis
   (a) Modes of transmission;
   (b) Precautions to take against contracting these diseases; and,
   (c) Current treatments and how to access them.

B. Transitional Residential and ~~Aftercare Programs~~ Recovery Support Services must also provide the services outlined, unless the program can provide documentation that the individual received the educational information prior to a transfer to a less restrictive level of care.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.4 ~~53.4~~ Service to Pregnant Women

B. All substance ~~abuse~~ use disorder programs must document and follow written policies and procedures that ensure:

1. Pregnant women are given top priority for admission;
2. Pregnant women may not be placed on a waiting list. Pregnant women must be admitted into a substance ~~abuse~~ use disorder treatment program within forty-eight (48) hours;
3. If a program is unable to admit a pregnant woman due to being at capacityor any other appropriate reason, the program must assess, refer and assist the individual with placement in another ~~certified~~ DMH certified program within forty-eight (48) hours;
4. If a program is unable to admit a pregnant woman, the woman must be referred to a local health provider for prenatal care until an appropriate placement is made;
5. If unable to complete the entire process as outlined, DMH Office of Consumer Support must be notified immediately by fax or email using standardized forms provided by DMH. The time frame for notifying DMH of inability to place a pregnant woman cannot exceed forty-eight (48) hours from the initial request for treatment from the individual;
6. If a program is at capacity and a referral must be made, the pregnant woman must be offered an immediate face to face assessment at the agency or another DMH certified provider. If offered at another DMH certified program, the referring provider must fully facilitate the appointment at the alternate DMH certified program. The referring provider must follow up with the certified provider and program to ensure the individual was placed within forty-eight (48) hours.
7. Written documentation of placement or assessment and referral of pregnant women must be maintained onsite and reported to the DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.5 ~~54.5~~ Services to Individuals Who Use IV Drugs

B. All DMH certified substance ~~abuse~~ use disorder programs must document and follow written policies and procedures that ensure:

9. Individuals who use IV drugs are provided priority admission over non-IV drug users.
10. Individuals who use IV drugs are placed in the treatment program identified as the best modality by the assessment within forty-eight (48) hours.

11. If a program is unable to admit an individual who uses IV drugs due to being at capacity or any other appropriate reason, the program must assess, refer and place the individual in another certified DMH program within forty-eight (48) hours.
12. If unable to complete the entire process as outlined in C., DMH Office of Consumer Support must be notified immediately by fax or email using standardized forms provided by DMH. The time frame for notifying DMH of inability to place an individual who uses IV drugs cannot exceed forty-eight (48) hours from the initial request for treatment from the individual.
13. If a program is at capacity and a referral must be made, the referring provider is responsible for assuring the establishment of alternate placement at another certified DMH program within forty-eight (48) hours.
14. The referring provider is responsible for ensuring the individual was placed within forty-eight (48) hours.
15. In the case there is an IV drug user that is unable to be admitted because of insufficient capacity, the following interim services will be provided:
    (a) Counseling and education regarding HIV and TB, the risks of sharing needles, the risk of transmission to sex partners and infants, and the steps to prevent HIV transmission; and
    (b) Referrals for HIV and TB services made when necessary.
16. Written documentation of placement or assessment and referral of IV drug users must be maintained onsite and reported to the DMH.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 49.6 ~~53.6~~ DUI Convictions

C. Service providers must determine and document, at intake, if the individual has been convicted of more than one DUI that has resulted in a suspended driver's license. If so, the provider must explain the DUI assessment and treatment process to the individual and determine if he/she is interested in participating.

D. Programs must disclose if they are certified by the DMH to conduct DUI assessments.

Part 2: Chapter 50: Withdrawal Management Services

Rule 50.1 General

B. The Withdrawal Management standards in this section are based on the *American Society of Addiction Medicine*© established criteria for Level 3.2-WM: Clinically Managed Residential Withdrawal Management (sometimes referred to as "social detox") and 3.7 Medically Monitored Inpatient Withdrawal Management.

E. These services must be provided in conjunction with the DMH certified Primary Residential services.

~~A. Withdrawal management is the process of interrupting the momentum of compulsive use in an individual diagnosed with substance dependence and the condition of recovery from the effects of alcohol or another drug and the treatment required to manage withdrawal symptoms from alcohol or another drug. Withdrawal management in an organized residential nonmedical setting delivered by appropriately trained staff who provide safe, twenty-four (24) hour monitoring, observation, and support in a supervised environment for an individual to achieve initial recovery from the effects of alcohol or another drugmedical physicals conducted must show evidence of a screening for the need for Withdrawal Management Services. This documentation can be the completed screening instrument or a statement naming the screening instrument with documentation of the results~~

F. ~~B.~~ All programs must utilize the results of a medical screening instrument(s) identifying the need for Withdrawal Management Services. The screening assessments should be conducted as often as the individual case warrants.

G. ~~C.~~ Programs providing Withdrawal Management Services must have written policies and procedures which specify the following:

4. An individual designated as responsible for coordinating Withdrawal Management Services;
5. A description of the method by which Withdrawal management Services are offered; and
6. A description of the method by which referrals are made to physicians and/or hospitals for appropriate medical intervention.
5. Criteria for admission, care, discharge, and transfer of a client to another level of care.

D. ~~Providers must use an appropriate standardized screening instrument (such as the CIWA-Ar, COWS) for each individual that uses any substance that may require withdrawal management [alcohol, benzodiazepines, and opiates (when mixed when used in combination with alcohol or benzodiazepines, or there is a history of health issues that place them at risk for complications)]. The screening assessments should be conducted as often as the individual case warrants.~~

E. ~~Withdrawal management in CSUs or provided through special withdrawal management funds provided by DMH through a contract with a local medical provider is made available only to individuals using benzodiazepines, and/or alcohol, using opiates in combination with benzodiazepines and/or alcohol are also eligible.~~

F. All Residential Programs must have a current contract on file with a Medically Managed Intensive Inpatient Withdrawal Management Provider. If applicable and funds are available The DMH will reimburse this contract for individuals experiencing physical withdrawals from benzodiazepines, and/or alcohol, individuals using opiates in combination with benzodiazepines and/or alcohol or individuals who have a history of a biomedical condition(s) that will complicate withdrawal. If the program is serving pregnant females, the following must be include:

1. The contract with the medical provider will state that women will not be detoxed during pregnancy without consideration by a physician or nurse practitioner of the impact it would have on the mother or her fetus.
2. All Residential Programs are responsible for ensuring that pregnant women are evaluated immediately by a physician, hospital, or medical clinic when symptoms of intoxication, impairment, or withdrawal are evident.
3. All Residential Programs must provide transportation for pregnant women that are referred to a physician, hospital, medical clinic or other appropriate Residential Facility.
4. Withdrawal management services for pregnant/prenatal women will take into account up-to-date medical research. ~~Programs providing Withdrawal Management Services must have:~~

   ~~1. A specific protocol for emergency care related to withdrawal management.~~
   ~~2. A trained staff member familiar with complications associated with alcohol and other drug use to include: a) intoxication and withdrawal as well as appropriate treatment of those conditions, b) supportive care, and c) community resources awake on all shifts; and~~
   ~~3. Clearly defined policies and procedures for admission, care, discharge, and transfer of a client to another level of care.~~

F. ~~G.~~ Programs should establish a protocol for immediate referral to an acute care facility such as:

1. The proper threshold score as established by the assessment instrument ~~or~~
2. When the individual has any one of the following:

   (n) Seizures or history of seizures;
   (o) Current persistent vomiting or vomiting of blood;
   (p) current ingestion of vomit in lungs;
   (q) clouded sensorium such as gross disorientation or hallucination;
   (r) a temperature higher that one hundred and one degrees Fahrenheit;

(s) abnormal respiration such a shortness of breath or a respiration rate greater than twenty-six (26) breaths per minute;
(t) elevated pulse such as a heart rate greater than one hundred (100) beats per minute or arrhythmia;
(u) hypertension such as blood pressure greater than one hundred sixty (160) over one hundred twenty (120);
(v) sudden chest pain or other sign of coronary distress or severe abdominal pain;
(w) unconscious and not able to be awakened; ~~or~~
(x) other signs of significant illness such as jaundice, unstable diabetes, acute liver disease, severe allergic reaction, poisoning, progressively worsening tremors, chills, severe agitation, exposure, internal bleeding shock
(y) uncontrollable violence,
(z) suicidal or homicidal ideations.

~~H. All substance abuse programs serving pregnant women must document and follow written policies and procedures that ensure:~~

~~1. Women will not be detoxed during pregnancy without consideration by a physician or nurse practitioner of the impact it would have on the mother or her fetus;~~
~~2. Pregnant women with symptoms of intoxication, impairment or withdrawal are immediately provided a) an evaluation by a physician, hospital or medical clinic; b) transportation to a physician, hospital or medical clinic; and c) admission for withdrawal management in a hospital when clinically indicated and/or provided non hospital services when not clinically indicated; and~~
~~3. Withdrawal management services for pregnant/prenatal women will take into account up-to-date medical research uncontrollable violence, suicidal or homicidal ideations.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

~~Rule 54.2 Use of American Society for Addiction Medicine (ASAM) Levels~~

~~A. Programs must use American Society for Addiction Medicine (ASAM) levels of care to determine compliance with withdrawal management standards. ASAM levels are as follows:~~

~~2. Level I-D: Ambulatory Withdrawal Management Without Extended On-site Monitoring (e.g., physician's office, home health care agency). This level of care is an organized outpatient service monitored at predetermined intervals.~~
~~3. Level II-D: Ambulatory Withdrawal Management With Extended On-Site Monitoring (e.g., day hospital service). This level of care is monitored by appropriately credentialed and licensed nurses.~~
~~4. Level III.2-D: Clinically Managed Residential Withdrawal Management (e.g., nonmedical or social detoxification setting). This level emphasizes peer and social~~

~~support and is intended for patients whose intoxication and/or withdrawal is sufficient to warrant 24-hour support.~~

~~5. Level III.7-D: Medically- Monitored Inpatient Withdrawal Management (e.g., freestanding detoxification center). Unlike Level III.2.D, this level provides 24-hour medically supervised detoxification services.~~

~~6. Level IV-D: Medically-Managed Inpatient Withdrawal Management (e.g., psychiatric hospital inpatient center). This level provides 24-hour care in an acute care inpatient settings.~~

~~B. Only providers that are an acute medical care facility may provide the following services:~~

~~1. Services defined as "Medically Managed" by the American Society of Addiction Medicine (ASAM)~~

~~2. Services that use or require Intravenous Hydration (IV)~~

~~3. Services that require Level IV, Medically-Managed Intensive Inpatient Services, as defined by the American Society of Addiction Medicine (ASAM).~~

~~C. Programs providing Withdrawal Management Services must ensure the provision of care for those whose withdrawal signs and symptoms are sufficiently severe enough to require twenty-four (24) hour structure and support, but the full resources of a medically managed inpatient withdrawal management (American Society of Addiction Medicine (ASAM) Level III 7.D) are not necessary.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 50.2 ~~54.3~~ Staffing and Observation

A. Programs providing Level 3.2-WM: Clinically Managed Residential Withdrawal Management Services must provide a level of services designed to safely assist individuals through withdrawal without the need for onsite medical and nursing personnel. Services must contain the following:

1. Appropriately credentialed personnel who are trained to provide physician approved protocols, and recognize signs and symptoms of alcohol and drug intoxication, withdrawal and appropriate monitoring of those conditions. Staff must:
   (a) Observe and supervise the individual
   (b) Determine the individuals appropriate level of care
   (c) Facilitate the individuals transition to continuing care
2. Twenty-four (24) hour a day medical evaluation and consultation.
3. A written agreement or contract with a local hospital able to provide Medically Managed Withdrawal Management Services as defined by ASAM.
4. Staff supervision self-administered medications must be appropriately licensed or credentialed by the state of Mississippi.

~~A. Programs providing Withdrawal Management Services must have:~~

~~1. A licensed physician on staff and available on a twenty-four (24) hour basis through affiliation agreement/contract, who has admitting privileges; and~~
~~2. A written agreement or contract with a local hospital able to provide Medically Managed Withdrawal Management Services as defined by ASAM.~~

C. Programs providing Level 3.7-WM: Medically Monitored Inpatient Withdrawal Management Services. This service provides care to individuals whose withdrawal signs and symptoms are sufficiently severe to require twenty-four (24) care delivered by medical and nursing professionals. Services must include the following:

1. Program staffed by a physician or appropriately licensed staff performing the duties as a physician under a collaborative agreement or other requirements of the medical practice act.
2. Physician or licensed designee must be available twenty-four (24) a day by telephone.
3. Individual must be assessed by a physician or licensed designee within twenty-four (24) of admission or earlier if medically necessary.
4. A registered nurse or other licensed and credentialed nurse is available to conduct a nursing assessment on admission.
5. Documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the withdrawal management program ~~and every two (2) hours during the following twenty-four (24) hours, and as needed thereafter, when Withdrawal Management Services are provided.~~
6. Programs providing ~~Withdrawal Management Services~~ this service must have a written plan describing the handling of medical emergencies which includes the roles of staff members and physicians.
7. Must have interdisciplinary team of appropriately trained staff available to assess and treat the individual's needs.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 51 ~~55~~: Substance ~~Abuse~~ Use Disorder Recovery Support Services

Rule 51.1 ~~55.1~~ General

D. Recovery Support Services are non-clinical services that are offered before, during and after ~~Primary Residential Treatment Services~~ any services that assist individuals and families working towards recovery from substance use disorders. They incorporate a full range of social, legal, and other resources that facilitate recovery and wellness to reduce or eliminate environmental or personal barriers to recovery. RSS include social supports, linkage to and coordination among allied service providers, and other resources to improve quality of life for people in and seeking recovery and their families.

E. The Recovery Support staff must maintain on site a comprehensive file of existing community resources. Each listed resource must include:

1. The name, location, telephone number and hours of operation of the resource;
2. The types of services provided by the resource;
3. Eligibility requirements; and
4. Contact person(s).

F. Recovery Support Staff must develop an annual plan for conducting community outreach activities that must include:

5. Each county in their catchment area
6. An emphasis on alcohol and other drug treatment and prevention services offered by their organization
7. A minimum of twelve (12) community activities per year and cannot be limited to exhibits or booths at community events
8. Identification of targeted community health providers, areas or populations such as workplaces of young adults, physicians, drug courts, etc.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 51.2 ~~55.2~~ Availability of Recovery Support Services

Recovery Support Services must be provided to individuals ~~residing within in the respective catchment area~~ regardless of where or if Primary Treatment Services have been completed.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 51.3 ~~55.3~~ Policies and Procedures

~~A. The program must establish and implement written policies and procedures and documentation that the following Substance Abuse Recovery Support Services are available:~~

~~1. Structured and organized group meetings with Recovery Support Staff a minimum of one (1) hour per week on a consistent basis~~
~~2. Individual sessions with Recovery Support Staff, as needed~~
~~3. Family sessions with Recovery Support Staff, as needed~~
~~4. Employer contacts, as needed~~
~~5. Referrals and linkage with additional needed services including medical, housing, legal, vocational, education and any other service or support that would work towards improving outcomes for the individual.~~

E. ~~B.~~ Recovery Support Services must establish a written policy which details a twelve (12) month step down approach for the delivery of Recovery Support Services. Emphasis must be placed on the "critical time" of the first six (6) months of service.

F. ~~C.~~ The highest level of frequency of contacts during the first one to three (1-3) months ~~following discharge~~ must include, at a minimum:

~~1. Weekly contact;~~
~~2. Minimum support attendance recommended such as AA meetings, faith based support groups, or other means of support as determined by the individual;~~
5. Face to face contact for a minimum of one hour weekly (more if determined to be necessary). This may be in the form of non-clinical psychoeducational groups, individual support, or family support sessions.
6. Community involvement is required. This may be in the form of 12 step meeting (s), volunteerism, faith based support groups or any other mutually agreed upon meaningful pro-social activity that supports recovery.
7. Weekly random drug ~~screens or weekly, if able; and~~ screen
8. ~~4.~~ Weekly family contact is required. If individual/family refuses to participate documentation is required.

G. ~~D.~~ The subsequent three (3) months must include, at a minimum:

5. ~~Biweekly~~ Face to face contact ~~Continued~~ for a minimum ~~support attendance as~~ of one hour every other week (more if determined ~~by and agreed upon with~~ to be necessary). This may be in the form of non-clinical psychoeducational groups, individual support sessions, or family support sessions.
6. ~~Random~~ Continued Community involvement is required. This may be in the form of 12 step meeting (s), volunteerism, faith based support groups or any other mutually agreed upon meaningful pro-social activity that supports recovery.
7. Monthly random drug screens; and

8. ~~As needed family contact, but a minimum of once per month.~~

9. Family contact as needed. If individual/family refused contact in the prior three months, it must be re-addressed and documentation is required.

H. ~~E.~~ The remaining six (6) months should be determined following outcomes of the first six (6) months.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 51.4 ~~55.4~~ Contacts

D. For the six (6) months immediately following completion of treatment, as described in Rule 55.2, Recovery Support staff must make at least one (1) attempt to contact each member per month. Group or individual sessions are acceptable as contacts.

E. Recovery Support Staff should attempt to contact individuals immediately, but not to exceed forty-eight (48) business hours, following a missed appointment.

F. Following a missed appointment, Recovery Support Staff must make at least three (3) separate attempts to contact each individual on their caseload prior to discharging the individual. A record of contacts/attempts must be maintained in the individual's record. Contact ~~should~~ must include the most appropriate means of engagement preferred by the individual to encourage continued participation ~~and can include~~ such as phone calls, face to face visits, letters, emails or other electronic technology as long as full confidentiality is maintained.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 52 ~~56~~: Substance ~~Abuse~~ Use Disorder Prevention Services

Rule 52.1 ~~56.1~~ General

D. ~~Prevention Services represent a process that involves interacting with people, communities, and systems to promote programs aimed at substantially preventing alcohol, tobacco, and other drug abuse, delaying its onset and/or reducing substance abuse-related behaviors.~~ Prevention Services are designed to reduce the risk factors and increase the protective factors linked to substance ~~abuse~~ use disorder and related problem behaviors to provide immediate and long-term positive results. The process begins prior to the onset of a disorder. These interventions are intended to prevent or reduce the risk of developing a behavioral health problem, such as underage alcohol use, prescription drug misuse and abuse, tobacco use, and illicit drug use.

E. ~~F.~~ No Prevention Services will be provided to persons who are actively engaged in any substance use and addictive disorders program. This includes individuals detained in a facility for drug related offenses.

F. ~~B.~~ All prevention programs must implement at least three (3) of the following six (6) strategies, required by the Center for Substance Abuse Prevention (CSAP) in the delivery of Prevention Services:

1. Information/dissemination
2. Affective education programs
3. Alternative programs
4. Problem/Identification and referral
5. Community-based process (Community development)
6. Environmental programs.

H. ~~C.~~ All DMH ~~funded~~ certified providers of Prevention Services must document all prevention activities on the designated Internet-based tool or other required tool by the tenth (10th) working day of the month following the reporting period.

I. ~~D.~~ All prevention providers must have a staff member designated to coordinate the prevention program.

J. ~~G.~~ Individuals working in prevention services must have their own working computer (provided by the certified provider) with internet access.

K. ~~E.~~ All prevention programs must show evidence of ongoing use of at least one (1) model, evidence-based curriculum recommended by the Center for Substance Abuse Prevention (CSAP). All programs are required to provide an evidenced-based curriculum schedule upon request. The percentage of ~~implementation to an~~ evidence-based curriculum implementation must adhere to BADS grant requirements.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 53 ~~57~~: DUI Diagnostic Assessment Services for Second and Subsequent Offenders

Rule 53.1 ~~57.1~~ General

D. The DUI Diagnostic Assessment is a process by which a diagnostic assessment (such as, Substance Abuse Subtle Screening Inventory (SASSI), or other DMH approved tool) is administered and the result is combined with other required information to determine the offenders appropriate treatment environment.

E. All DMH certified programs which conduct DUI Assessments must have a designated staff member(s) responsible, accountable, and trained to administer the assessment and implement the program procedures.

F. The program must have written policies and procedures and adhere to those policies and procedures which describe:

1. ~~The manner in which treatment components of the DUI Assessment Process are provided~~
1. ~~2.~~ The criteria by which the treatment environment is determined
2. ~~3.~~ The criteria by which successful completion of treatment is determined for DUI offenders
3. ~~4.~~ The process by which an individual is admitted into a substance ~~abuse~~ use disorder treatment program following completion of the DUI Diagnostic Assessment.

D. The DUI Diagnostic Assessment must consist of the following components and be documented in the individual's case file:

1. Motor Vehicle Report from an official governmental source such as the MS Department of Public Safety~~, or comparable agency (or a copy of a dated written request to DPS) i.e., release of information document or form~~.
2. Results and interpretation of the SASSI, or other DMH Bureau of Alcohol and Drug Abuse approved tool. In order to administer the diagnostic tool, at least (1) one staff member must be certified.
3. An Initial Assessment.

E. Individuals receiving DUI ~~assessment/~~ treatment services through a DUI Outpatient Program ~~Track~~ must receive a minimum of twenty (20) hours of direct service (individual and/or group therapy), in no less than ten (10) separate therapeutic sessions or as otherwise specified by the DMH BADS, before receiving the DMH Certification of DUI In-Depth Diagnostic Assessment and Treatment Form. Documentation of treatment will be maintained in the individual's record.

F. All DUI Diagnostic Assessment/Treatment Programs must submit the DMH Certification of DUI In-Depth Diagnostic Assessment and Treatment Form and a release of

information to the BADS ~~within ten (10) working days of~~ when an individual has successfully completed the treatment program.

G. All DUI Diagnostic Assessment services must be equipped to provide each individual the type of substance ~~abuse~~ use disorder treatment indicated by the results and interpretation of the assessment (components listed in this section above). Substance ~~abuse~~ use disorder treatment may be offered through the assessment service and/or through an affiliation agreement with a DMH certified substance ~~abuse~~ use disorder treatment program. The assessment service must be able to provide, at a minimum, outpatient and primary residential or inpatient chemical dependency substance ~~abuse~~ use disorder treatment.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

~~Part 2: Chapter 58: Residential Treatment Services for Alcohol and Drug Abuse~~

~~Rule 58.1 Transitional Substance Abuse Rehabilitation and Treatment Services~~

~~A. Transitional Substance Abuse Rehabilitation Services are provided in a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational or related opportunities. With group support, individuals acquire coping skills which enable them to become productive citizens in their communities.~~

~~B. Staffing must be sufficient to meet service requirements. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week.~~

~~C. An individual must have successfully completed a primary substance abuse treatment program in order to be eligible for admission to transitional residential services. The primary substance abuse treatment program must be at least thirty (30) days long.~~

~~G. The program must have a written master schedule of activities and must document provision of the following services:~~

~~1. At least one (1) hour of individual therapy per week with each individual~~
~~2. Group therapy must be offered to individuals based on their individual needs and stage of recovery~~
~~3. Family therapy~~
~~4. Educational services addressing substance abuse and addiction, self-help/personal growth, social skills, anger management, the recovery process, and a philosophy of living which will support recovery~~
~~5. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval)~~
~~6. Vocational, educational, employment or related activities.~~

~~H. Transitional Substance Abuse Services that serve pregnant and parenting women/legal representatives with young children who reside on the program site must adhere to the following:~~

~~9. Provide adequate, secure, and supervised play space for the children of women served in the program~~
~~10. Prohibit any form of corporal punishment by staff or individuals receiving services. Staff must provide residents with information regarding positive approaches to management of their children's behavior.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 58.2 Primary Substance Abuse Rehabilitation and Treatment Services~~

~~A. Primary Substance Abuse Rehabilitation Service is an intensive residential program for individuals who are addicted to or abuse alcohol or other drugs. This type of treatment offers a group living environment in order to provide the individual with a comprehensive program of services that is easily accessible and responsive to his/her needs.~~

~~B. Because alcohol and other drug disorders are a multidimensional problem, various treatment modalities can be made available through the program. These include: group, individual, and family therapy; education services explaining alcohol/drug dependency, personal growth, and the recovery process; vocational and rehabilitation services and employment activities; and recreational and social activities. This program facilitates continuity of care throughout the rehabilitation process.~~

~~C. Individuals admitted into Primary Substance Abuse Rehabilitation and Treatment Services must receive a medical assessment within forty-eight (48) hours of admission to screen for health risks.~~

~~D. Primary Substance Abuse Rehabilitation Services for children or youth must also comply with Rule 30.4.~~

~~E. Programs must ensure access to the following services either through program staff or affiliation agreement/contract:~~

~~1. A licensed psychiatrist with experience in the treatment of substance abuse/addiction or~~
~~2. A licensed psychologist with experience in the treatment of substance abuse/addiction and~~
~~3. A licensed physician with experience in the treatment of substance abuse/addiction.~~

~~F. Caseloads for Primary Substance Abuse Rehabilitation residential program staff must be no more than twelve (12) adults or eight (8) adolescents.~~

~~G. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week.~~

~~H. The program must have a written master schedule of activities and must document provision of the following services:~~

~~1. At least one (1) hour per week of individual counseling with each individual~~
~~2. At least five (5) hours per week of group counseling with each individual~~
~~3. Involvement of family by having at least two (2) family therapy sessions available during the course of treatment~~

4. ~~At least twenty (20) hours per week of education services dealing with substance abuse and addiction, self-help/personal growth, increasing self-esteem, wellness education, social skills, anger management, the recovery process, and a philosophy of living which will support recovery~~
5. ~~At least three (3) hours of family-oriented education activities~~
6. ~~Therapeutic and leisure/recreational/physical exercise activities (with physician's approval)~~
7. ~~Vocational counseling and planning/referral for follow-up vocational services~~
8. ~~For child/youth, the academic schedule indicating school hours.~~

I. ~~Primary Substance Abuse Rehabilitation residential programs serving pregnant and parenting women/legal representatives with young children who reside on the program site must adhere to the following:~~

1. ~~Adequate, secure, and supervised play space for the children of women served in the program must be provided; and~~
2. ~~Any form of corporal punishment by staff or individuals receiving services is prohibited. Staff must provide residents with information regarding positive approaches to management of their children's behavior.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

~~Rule 58.3 Environment and Safety for Primary and Transitional Substance Abuse Rehabilitation and Treatment Services~~

L. ~~This rule (58.3) applies to environmental and safety requirements that are in addition to or more stringent than the requirements in Chapter 13 and are specific to Primary and Transitional Substance Abuse Rehabilitation and Treatment Services.~~

M. ~~The provider must assign, maintain and document on-site staff coverage twenty-four (24) hours a day and seven (7) days a week with a staff member designated as responsible for the program at all times and male/female staff coverage when necessary.~~

N. ~~All providers must ensure that programs have furnishings that are safe, comfortable, appropriate, and adequate.~~

O. ~~All providers must ensure visiting areas are provided for residents and visitors:~~

1. ~~Programs (all types) serving less than thirteen (13) residents must have at least one (1) visiting area;~~
2. ~~Programs (all types) serving thirteen (13) or more persons must have two (2) visiting areas;~~
3. ~~Each visiting area must have at least two (2) means of escape.~~

P. ~~All providers must ensure the laundry room has an exterior mechanical ventilation system for the clothes dryer.~~

~~F. All programs must have separate storage areas for:~~

~~1. Sanitary linen;~~

~~2. Food (Food supplies cannot be stored on the floor.); and~~

~~3. Cleaning supplies.~~

~~G. All programs must ensure an adequate, operable heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.~~

~~H. All program of two stories or more in height where residents are housed above the ground floor must be protected throughout by an approved automatic sprinkler system and a fire alarm and detection system (all systems must be operable).~~

~~C. Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom, hallways and/or corridors, and common areas;~~

~~D. Programs using fuel burning equipment and/or appliances (i.e. gas heater, gas water heater, gas/diesel engines, etc.) must have carbon monoxide alarms/detectors placed in a central location outside of sleeping areas;~~

~~E. Each bedroom must have at least two means of escape~~

~~F. Residents must not have to travel through any room not under their control (i.e. subject to locking) to reach designated exit, visiting area, dining room, kitchen, or bathroom; and,~~

~~G. Two (2) means of exit per living area must be provided and must be readily accessible at all times, remote from each other, and so arranged and constructed to minimize any possibility that both may be blocked by fire or other emergency condition.~~

~~H. Programs must have the capacity to monitor unauthorized entrance, egress, or movement through the facility; and,~~

~~I. Resident bedrooms must have an outside exposure at ground level or above. Windows must not be over forty-four inches off the floor. All windows must be operable.~~

~~J. Resident bedrooms must meet the following dimension requirements:~~

~~1. Single room occupancy - at least one hundred (100) square feet~~

~~2. Multiple occupancy - at least eighty (80) square feet for each resident~~

~~K. Resident bedrooms must house no more than three (3) persons each;~~

~~L. Resident bedrooms must be appropriately furnished with a minimum of a single bed and chest of drawers and adequate storage/closet space for each resident;~~

~~S. Resident bedrooms must be located so as to minimize the entrance of unpleasant odors, excessive noise, or other nuisances;~~

~~T. Beds must be provided with a good grade of mattress which is at least four inches thick on a raised bed frame. Cots or roll-away beds may not be used; and~~

~~U. Each bed must be equipped with a minimum of one pillow and case, two sheets, bedspread, and blanket(s). An adequate supply of linens must be available to change linens at least once a week or sooner if they become soiled.~~

~~V. All programs must have a bathroom with at least one (1) operable toilet, one (1) operable lavatory/sink and one (1) operable shower or tub for every six (6) residents.~~

~~E. All programs must ensure bathtubs and showers are equipped with:~~

~~1. Soap dishes;~~
~~2. Towel racks;~~
~~3. Shower curtains or doors; and~~
~~4. Grab bars (as needed by the residents).~~

~~Rule 58.4 Chemical Dependency Units~~

~~A. Chemical Dependency Unit Services include inpatient or hospital-based services for individuals with more severe alcohol or other drug disorders and who require a medically-based environment. Treatment usually includes withdrawal management, group, individual, and family therapy, education services explaining alcohol/drug dependency, personal growth, the recovery process, aftercare, and family counseling.~~

~~B. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week.~~

~~C. Programs serving children or youth must also comply with Rule 30.4.~~

~~D. The program must have a written master schedule of activities and must document provision of the following services:~~

~~1. At least one (1) hour of individual counseling per week with each individual;~~
~~2. At least five (5) hours per week of group counseling with each individual;~~
~~3. Family counseling;~~
~~4. At least ten (10) hours per week of education services dealing with substance abuse and addiction, self-help/personal growth, social skills, anger management, recovery process, and a philosophy of living which will support recovery;~~
~~5. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);~~
~~6. Vocational counseling and planning/referral for follow-up vocational services; and,~~
~~7. For children and youth, the academic schedule indicating school hours.~~

~~Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*~~

Part 2: Chapter 54 ~~59~~: Opioid Treatment Services ~~Utilizing Methadone~~

Rule 54.1 ~~59.1~~ General Related to Opioid Treatment Programs

E. The Mississippi Department of Mental Health (DMH), Bureau of Alcohol and Drug Services (BADS), will serve as the State Authority for Opioid Treatment Programs under the authority provided under state statute (Section 41-4-7 of the Mississippi Code of 1972, Annotated). Such programs shall ~~detoxify~~ provide withdrawal management services to people suffering from chronic ~~opiate addicts from~~ addiction to opiates/opiate derivatives ~~and maintain the chronic opiate addict~~. The services support the individual by utilizing ~~a synthetic narcotic until~~ methadone, and/or Buprenorphine while the individual ~~can achieve recovery through~~ participates in a spectrum of counseling and other ~~supportive/rehabilitative~~ recovery support services directed toward ~~providing~~ that are intended to assist the ~~opportunity for the addict to successfully withdraw~~ person with successful recovery from ~~the~~ opiate addiction.

B. ~~Programs providing~~ Providers of Opioid Treatment ~~Services~~ Programs (OTP) shall comply with all applicable federal, State, and local laws, codes, and/or rules to include, but not be limited to, those promulgated/administered by or through the United States Department of Health and Human Services (DHHS), SAMHSA, Drug Enforcement Administration (DEA) regulations, and the Controlled Substances Act (21 U.S.C. 823 (g) (l).

C. An Opioid Treatment Program must have a current, valid certification from SAMHSA and permanently display proof of that current certification in public view, available for public inspection. Additionally, Opioid Treatment Programs must have a current certification from the Commission on Accreditation of Rehabilitation Facilities (CARF).

D. The operation of each Opioid Treatment Program must be in compliance with the Mississippi Pharmacy Practice Act (Section 73-21-69 et. seq. of the Mississippi Code as Annotated, 1972) as well as current rules and regulations promulgated by the State Board of Pharmacy; and must at a minimum obtain and maintain a "Pharmacy Permit," as defined and authorized by the Mississippi Board of Pharmacy.

~~E. Each individual receiving services must be re-assessed by the Medical Director annually for the need for the continued Opiate Treatment Services.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.2 ~~11.9~~ Staffing/~~Qualifications~~ for Opioid Treatment Programs ~~Utilizing Methadone~~

A. An Opioid Treatment Program must employ sufficient and qualified staff to meet the treatment and support needs of the population served. Services must be provided by an interdisciplinary team, all of whom are properly licensed, registered, or certified by

the appropriate authority in accordance with Mississippi law. At a minimum, the staff must include:

1. A licensed physician;
2. A Registered Nurse;
3. A Licensed pharmacist, and
4. Licensed psychologist/counselor/social worker, licensed/certified mental health therapist (specialized in ~~alcohol/drug addiction~~ substance use and disorders services) who must be on-site during all hours of operation. The ~~counselor~~ therapist to individual ratio must be set with a limited caseload that supports and meets the needs of the individuals receiving services and limits must be addressed in the agency's policies and procedures. ~~cannot exceed 1:75 (one (1) counselor per seventy-five (75) individuals served by the program)~~.

F. An Opioid Treatment Program must designate a medical director/staff physician who is responsible for administering and supervising all medical services performed by the program. The medical director/staff physician must be a physician licensed in the State of Mississippi. He/she must be on site as needed to complete all medical needs in accordance with standard medical practice and available by phone as needed.

G. An Opioid Treatment Program must employ at least one full-time Registered Nurse (RN) for the first 100 or fewer individuals. In addition to the one full-time registered nurse additional registered nurses must be maintained so as to provide nursing services at least one (1) hour per week per five (5) individuals enrolled over 100 individuals. (For example a program serving 150 individuals would have one full-time RN and an additional ten (10) hours per week of RN time from another RN on staff). Nursing functions may be supplemented by a licensed practical nurse, if a registered nurse or physician is on-duty. All nursing services provided must be in compliance with the Mississippi Nursing Practice Act (Section 73-15-1 et. seq. of the Mississippi Code of 1972 as Annotated) and current rules and regulations promulgated by the Mississippi State Board of Nursing.

H. A person may hold more than one staff position within the facility if that person is qualified to function in both capacities, and the required hours for each job are separate and apart for each position.

I. All Opioid Treatment Programs must provide availability of staff seven (7) days a week, twenty-four (24) hours a day. A record of the on-call schedule must be maintained and the individuals must be informed of how to access the on-call staff; therefore, a signed statement by the individual must be maintained in the individual's record. The on-call staff must be available at all times for emergencies of the individuals served. The on-call staff must have access to pertinent individual information including dosage levels.

Rule 54.3 ~~59.2~~Admissions to Opioid Treatment Programs

B. The Opioid Treatment Program must have written policies and procedures to describe the total process for admission to the program and must at a minimum include:

3. A face-to-face with each person requesting methadone maintenance treatment services;
4. Documentation and identification of the individual's immediate/urgent need (s);
5. ~~Criteria for admission;~~
6. ~~Criteria for waiting list (a plan must be documented);~~

~~5. Any specific conditions/situations that would exclude an individual from being eligible for admission. Provisions for recommendations for alternate services must be included.~~

4. Admission criteria must ~~be delineated as part of written policies and procedures maintained by the programs. Admission criteria must~~ include, but not be limited to the following:

(l) Current diagnosis of opioid dependence in accordance with the Diagnostic and Statistical Manual of Mental Disorders (Current Edition).

(m) Individual is at least 18 years old; as evidenced by:

(3) Driver's license; or

(4) Birth certificate or Social Security card;

(n) Individual meets the federal requirements, including exceptions, regarding determination that individual is currently addicted to opiates and has been addicted to opiates for at least one (1) year prior to admission;

(o) Individual is not currently enrolled in another Opioid Treatment Program;

(p) Individual has signed a statement to evidence his/her understanding of the risks and side effects;

(q) Individual has signed a statement to evidence his/her understanding of the options concerning all treatment procedure in Opioid Replacement Management;

(r) Individual has signed a statement evidencing that admission is voluntary;

(s) Individual has been informed of and received a copy of rights of individuals served by the program, including confidentiality (a signed copy must be maintained in the individual's record);

(t) Individual has been informed of and received a copy of program rules (signed documentation of receipt of program rules must be maintained in the individual's case record)

(u) Individual has received counseling, testing, and education regarding HIV, Hepatitis B, Hepatitis C, tuberculosis, and sexually transmitted diseases (documentation must be maintained in the individual's record); and

(v) Individual ~~has had a physical examination, including a medical examination~~ must have signed documentation that they understand the fee schedule and

~~related laboratory test within fourteen (14) days prior~~v tapering process due to ~~admission~~ inability to pay for services.

6. Criteria for waiting list (a plan must be documented);
7. Any specific conditions/situations that would exclude an individual from being eligible for admission. ~~the program (A copy~~ Provisions for and documentation of recommendations for alternate services must be included.

C. Each individual must be provided an orientation prior to administration of any medication. The orientation must be documented by a signed statement that is maintained in the case record which proves the individual acknowledges receipt of a program handbook. The program handbook must include, but is not limited to the following:

~~D. The admission criteria must require that the following minimum data are documented in the case record:~~

~~1. Driver's license;~~

11. Signs and symptoms of overdose, and conditions for seeking emergency assistance;
12. Description of the medications to be administered by the program, including potential risks, benefits, side effects, and drug interactions;
13. The nature of addictive disorders;
14. The goals and benefits of medication-assisted treatment and the process of recovery;
15. Voluntary and involuntary discharge procedures;
16. Toxicology (UDS) testing procedures;
17. Medication dispensing procedures;
18. Hours of operations;
19. Medication fee schedule; and
20. Counseling services offered during treatment.

~~2. and~~

~~3. The individual's efforts at abstinence-based treatment (i.e. intensive outpatient, residential treatment, or inpatient substance abuse treatment) prior to admission to the Opioid Treatment Program.~~

~~E. Current addiction must include documentation describing the following:~~

~~1. Degree of dependence on narcotics/opiates;~~

~~2. Route of administration;~~

~~3. Old/new needle marks; and~~

~~4. Arrest records.~~

D. ~~E.~~ Each individual must be reviewed prior to admission and annually thereafter from the date of admission on the Prescription Drug Monitoring Program (~~PDMH~~PDMP) in MS and nearby states for which access is available to assess for appropriateness of ~~Opiate~~ Opioid Treatment Services. No individual is eligible for admission or continued

services/treatment whose review indicates the potential for diversion~~ and/or abuse of Methadone.~~. Each PDMP access shall confirm the individual is not seeking prescription medication from multiple sources. The program shall access the PDMP:

6. Upon admission;
7. Before initial administration of methadone or other treatment in a opioid treatment program;
8. Prior to requesting any Take-Home dosing exceptions and shall submit the resulting report to the State Opioid Treatment Authority (SOTA) with the exception request;
9. After any positive drug test for prescription medication; and
10. Every six months to determine if controlled substances other than methadone are being prescribed for the individual. The individual's record shall include documentation of the results of the PDMP database check and the date upon which it occurred.

E. No Program shall provide any form of consideration, including but not limited to free or discounted services or medication, for referral of potential clients to the Program.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.4 ~~59.3~~ Opioid Treatment ~~Strategies Provided in Conjunction with Opiate Replacement Therapy~~Program Services

B. Medical Services must be provided by the Medical Director~~/staff physician~~ of the program. The Medical Director must:

7. Be a physician licensed under Mississippi law who has been designated to oversee all medical services of a provider and has been given the authority and responsibility for medical care delivered by a provider. This includes ensuring the program is in compliance with all federal, state, and local laws and regulations regarding the medical treatment of addiction to an Opioid drug.
8. Be ASAM certified; have documented references in working experience in an opioid treatment program and have documented education in addiction services.
9. Be available to the program on a continual basis, seven (7) days per week, twenty-four (24) hours per day.
10. Be present or ensure that qualified medical personnel are present in the program location for two (2) hours per week for each fifty (50) clients enrolled.
11. Complete a full physical and biopsychosocial evaluation for each client annually to re-confirm for the need for the continued participation in the OTP.
12. Ensure that a Pharmacist licensed by the state of Mississippi is present and overseeing the dispensing of medication at each program location.

D. Program Services much include, but are not limited to, the following:

2. ~~An~~ Medical Services under the direction of the Medical Provider will include an initial history and physical evaluation to determine diagnosis and if the individual meets

criteria for methadone maintenance treatment (MMT); unless the individual can provide documentation of a medical examination (including laboratory test results) that was conducted within fourteen (14) days prior to admission. The physical evaluation will include but not be limited to the following:

(g) A complete medical history;

(h) Baseline toxicology report produced from a urine drug screen (UDS) that includes at a minimum testing for the following substances using the following cutoff concentrations:

(10)	Opiates	100 ng/ml;
(11)	Methadone	300 ng/ml;
(12)	Benzodiazepines	200 ng/ml;
(13)	Barbiturates	200 ng/ml;
(14)	Cocaine	300 ng/ml;
(15)	Amphetamines	1000 ng/ml;
(16)	Tetrahydrocannabinol	100 ng/ml;
(17)	Alcohol	.03 gm/dl;
(18)	Any other drug known to be frequently used in the locality of the OTP.	

(i) A tuberculosis (TB) skin test or chest x-ray if the skin was ever previously positive;

(j) Screening for STDs;

(k) Other laboratory tests as clinically indicated by the client's history and physical examination; and

(l) A pregnancy test shall be completed, and the results documented, for each female of childbearing potential prior to the initiation of Opioid treatment, medically-assisted withdrawal, or detoxification procedures.

7. Provide for the medical needs (annual physical exams, prescribing of medications, follow up evaluations, ordering and review of lab work), of the individuals being served in accordance with current standards of medical practice;
8. Ensure that the program is in compliance with local, state, and federal guidelines as they relate to the medical treatment of opioid addiction;
9. Determine the adequate treatment dose of methadone to meet the needs of the person served;
10. Provide for dosing and counseling services seven (7) days each week;
11. Establish hours of operations that are flexible to accommodate the majority of client school, work, and family responsibility schedules;
8. Maintain physical plant that is adequate in size to accommodate the proposed number of clients, required program activities, and provide a safe, therapeutic environment that supports enhancement of each client's well-being and affords protection of privacy and confidentiality;
9. Reconcile administration and dispensing medication inventory;
11. Approve all take-home medications; and
12. Participate in treatment planning including approval and signing of all plans.

C. ~~B.~~ Nursing Services provided must be in compliance with the Mississippi Nursing Practice Act (Section 73-15-1 et. seq. of the Mississippi Code of 1972 as Annotated) and current rules and regulations promulgated by the Mississippi State Board of Nursing. These duties and responsibilities are in addition to requirements of the Operational Standards for Mental Health, Intellectual/Developmental Disabilities, and Substance Abuse Community Service Providers and must include the following:

6. Administration of all methadone medication as prescribed by the licensed ~~medical director~~ Medical Director/physician;
7. Documentation of all medication administered and countersigning of all changes in dosage schedule;
8. Provision of general nursing care in addition to alcohol and drug services when ordered by the program's licensed medical director Medical Director/ physician;
9. Supervision of functions that may be supplemented by a licensed practical nurse; and
10. Participation in treatment team meetings.

D. ~~C.~~ Counseling and Recovery Support Services are a part of a holistic approach to treating the opiate addicted individual. Counseling services must be provided by a licensed psychologist, licensed professional counselor, licensed certified social worker or DMH credentialed addictions therapist and must be provided in accordance with the following requirements:

7. Written documentation must support decisions of the treatment team including indicators such as a positive drug screens, inappropriate behavior, criminal activity, and withdrawal management procedures.
8. Counseling must be provided individually or in small (not to exceed 12 individuals) groups of individuals with similar treatment needs.
9. Each individual must be assigned to a primary counselor and the counselor must be familiar with all individuals on his/her caseload and document all contacts in the individual's record.
10. Specialized information and counseling approaches for individuals who have special problems, i.e., terminal illness must be provided and documented; ~~and~~
11. Counselors must assess the psychological and sociological backgrounds of individuals, contribute to the treatment team, and monitor individual treatment programs.
12. Counselor to individual ratio cannot exceed 1:~~75~~40 (one counselor to every ~~seventy-five (75~~forty (40) individuals served by the program).

E. ~~D.~~ Through the provision of Counseling Services, therapeutic interventions must ~~meet~~ be available as needed but at a minimum of the following:

7. ~~Therapeutic models such as Twelve Steps,~~ Evidence-based therapeutic programs/practices, stress/anxiety management and relapse prevention must be included as a schedule of therapeutic interventions.

8. Individual, group or family therapy sessions must be provided for one (1) hour per week for the first ninety (90) days of treatment.
9. Individual, group, or family therapy sessions must be provided for two (2) hours per month for days ninety-one (91) through one hundred eighty (180) of treatment.
10. Individual, group or family therapy sessions must be provided for one (1) hour per month for the remainder of treatment.
11. Provide referrals for special needs.
12. Provide focused counseling in cases of psychosocial stressors such as:
    (a) Abuse/neglect (known or suspected);
    (b) Marital (relationship);
    (c) Pregnancy;
    (d) Financial/legal;
    (e) Vocational/educational;
    (f) Infectious disease; and/or
    (g) Other services as ordered/indicated.

F. ~~E.~~ Women's Services must be provided to ensure accessibility of services to pregnant women. ~~The Opioid Treatment Program must test women of childbearing age for pregnancy at the time of admission unless the intervention is deemed unnecessary by the medical director/physician~~ The program must develop, maintain, and document implementation of written policies and procedures to ensure the provision and accessibility of adequate services for women. The program must governed by but is not limited to the following which must be documented in the client record:

~~F. Women's Services include the implementation of written policies and procedures to ensure access to services. The program must:~~

11. Give priority to pregnant women in its admission policy;
    (c) Cannot deny admission solely on the basis of the pregnancy;
    (d) If a program is unable to provide services for a pregnant women, the State Opioid Treatment Authority much be notified as to how the program will assist the pregnant women in locating services;
12. Arrange for and document medical care during pregnancy by appropriate referral, and written and recorded verification that the individual receives prenatal care as planned;
13. Implement informed consent procedures for individuals who refuse prenatal care to ensure the individual acknowledges in writing that she was offered prenatal treatment but refused; ~~and~~
4. Ensure that the pregnant individual is fully informed of the possible risks to her unborn child from continued use of illicit drugs or from a narcotic drug administered during maintenance or withdrawal management treatment;
6. Ensure that the pregnant individual is fully informed of the possible risks and benefits to her unborn child from participating in the OTP;

7. Document implementation of the process to provide pregnant clients with access to or referral for prenatal care, pregnancy/parenting education, and postpartum follow-up.
8. Obtain written consent to reciprocally share client information with existing medical provider or future medical providers that has been or will be treating the pregnant women
9. For pregnant women who refuse appropriate referral for prenatal services, the program shall:
   (a) Utilize informed consent procedures to have the client formally acknowledge, in writing, that the OTP offered a referral to prenatal services that was refused by the client;
   (b) Provide the client with the basic prenatal instruction on maternal, physical, and dietary care as part of the OTP counseling services and document service delivery in the clinical record;
10. Provide written documentation of implementation for the following procedures to care for pregnant women:
   (a) Clients who become pregnant during treatment shall be maintained on the pre-pregnancy dosage, if effective, as determined by the Medical Director;
   (b) Dosing strategies will be consistent with those used for non-pregnant clients unless otherwise indicated;
   (c) Methadone dose shall be monitored more intensely during the third (3) trimester;
11. The program shall document in writing and file in the clinical record the decision by and process utilized for a pregnant woman who elects to withdraw from methadone with documentation to include the following minimum requirements.
   (a) The Medical Director shall supervise the withdrawal process.
   (b) Regular fetal assessments, as appropriate for gestational age, shall be part of the withdrawal process.
   (c) Education shall be provided on medically supervised withdrawal and the impact of medically supervised withdrawal services on the health and welfare of unborn children.
   (d) Withdrawal procedures shall adhere to accepted medical standards regarding adequate dosing strategies.
   (e) When providing medically supervised withdrawal services to pregnant women who withdrawal symptoms cannot be eliminated, referrals to inpatient program shall be made.
   (f) The program shall describe in writing and document implementation of policies and procedures, including informed consent, to ensure appropriate post-pregnancy follow-up and primary care for the new mother and well-baby care for the infant.
11. Maintain documentation of an annual review by the Medical Director of the protocol for treating pregnant females.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.5 ~~59.4 Opiate Replacement Therapy~~ Medication Management for Opioid Treatment Programs

A. The medication used in the treatment of opiate addiction must at a minimum:

5. Be approved by the Food and Drug Administration (FDA);
6. Be administered only as authorized and directed by orders signed by the ~~progam's~~ medical director ~~physician;~~
7. Be dispensed according to product pharmaceutical label; and
8. Be appropriate to produce the desired response for the desired length of time.

D. Urine drug screening (UDS) must be included as one source of information in making programmatic decisions, monitoring drug use, and making decisions regarding individual's capability to receive take-home medication. They must NOT be used as the sole criterion to discharge a client from treatment.

E. The Program must include methodology for conducting a urine drug screening in its policies and procedures that at a minimum, ensures the following:

11. Urine specimens are obtained in a treatment atmosphere of trust and safety, rather than of punishment and power;
12. Results of all drug testing shall be filed in the client's clinical record;
13. Urine testing shall be documented and performed by a laboratory certified by an independent, federally approved accreditation entity;
14. Specimen testing includes the same panel and cutoff concentrations as the baseline toxicology report;
15. Specimens are obtained randomly on the basis of the individual clinic visit schedule; but no less than twice a month for the first thirty (30) day and a minimum of eight (8) times in any twelve (12) month period.
16. Individuals have signed a statement that he/she has been informed about how urine specimens are collected and of the responsibility to provide a specimen when asked (a signed statement must be maintained in the individual's record);
17. The bathroom used for collection is clean and always supplied with soap and toilet articles;
18. That specimens are collected in a manner that minimizes falsification; if using direct observation, the procedures must be carried out ethically and professionally.
19. That results of urine screens are communicated promptly to individual to facilitate rapid intervention with any drug that was disclosed or with possible diversion of methadone as evidenced by lack of methadone or its metabolites in the urine; and,

~~10. That a schedule is provided for frequency of urinalysis as determined by the clinical team,~~

20. The program will develop a specific, DMH approved policy, requiring that blood serum testing will be done on an individual if there is any reason for suspicion that the urine testing is incorrect or in any manner thought to be false. This policy must be developed and approved prior to opening the program.

E. The program must have written policies and procedures that outline the documentation and implementation of standard procedures for addressing a Failed Urine Drug Screen, which is defined as positive toxicology results for illicit drugs and/or negative results for drugs provided by the OTP in the course of opioid maintenance therapy. These policies and procedures must include, but are not limited to the following:

1. Baseline toxicology testing results shall be discussed with the client and documentation of this discussion recorded as a progress note in the clinical record;
2. For new clients who are within the first ninety (90) days of treatment, a failed urine drug screen will be discussed by the counselor and the client during the next clinic visit to review the treatment plan and modify services as needed.
3. For clients with take-home privileges:
   (a) The first failed urine drug test will result in the following:
      (1) Client will be placed on probation for ninety (90) days;
      (2) Client will receive a minimum of two (2) random drug screens per month during the probationary period; and
      (3) Client must be required to meet with his/her primary counselor to discuss toxicology results and individual service plan.
   (b) The second failed urine drug test will result in the following:
      (1) Client will be transferred to a lower dosing phase;
      (2) Client will receive a minimum of two (2) random drug screens per month during the probationary period; and
      (3) Client must be required to participate in a clinical staffing with the treatment team to develop and implement a remedial plan.
   (c) The third and subsequent failed urine drug test will result in the following:
      (1) Complete biopsychosocial re-assessment;
      (2) Complete medical re-evaluation of medication dosage, plasma levels, metabolic responses and adjustment of dosage;
      (3) Assessment for co-occurring disorders and modifications to treatment protocol as needed;
      (4) Increase in counseling services, change in primary counselor and/or family intervention as appropriate; and
      (5) Consideration of alternative opioid addiction treatment.
   (d) The sixth consecutive failed urine drug test will result in the client being informed that administrative withdrawal procedures will begin immediately and a referral made to the appropriate level of care unless the Medical Director:
      (1) Provides objective clinical contraindications of the need for this action; and

(2) Develops a written intervention plan in consultation with the client and the treatment team to detoxify from any substance not prescribed by the OTP, and intensify counseling.

F. When dispensing Methadone the program must:

6. Ensure that each medication administration and dosage change is ordered and signed by the program ~~medical director/physician~~ Medical Director;
7. Ensure that administration of each dose is documented in the individual's record;
8. Ensure that administration of each dose is documented in the medication sheets;
9. Document administration of the dose with signature or initials of the qualified person administering the medication; and
10. Document the exact number of milligrams of the medication dispensed with daily totals.

G. The initial dose of methadone should be prescribed by the Medical Director~~/physician~~, based on standard medical practice and sound clinical judgment. The initial total daily dose for the first day may not exceed 30 mg unless the ~~physician~~ Medical Director documents in the individual's record that 30 mg did not suppress opiate abstinence symptoms.

J. ~~The determination for Take Home Medication privileges must be made by the treatment team and documented in the individuals record, with documentation at a minimum, the following~~ Subsequent doses of medication shall be:

1. Individually determined based upon the Medical Director's evaluation of the history and present condition of the client.
2. Reviewed and updated as according to the client's treatment plan and in consideration of the following criteria:
   (a) Cessation of withdrawal symptoms
   (b) Cessation of illicit opioid use as measured by:
      1. Negative drug tests; and
      2. Reduction of drug-seeking behavior
   (c) Establishment of a blockade dose of an agonist
   (d) Absence of problematic craving as measured by:
      1. Subjective reports; and
      2. Clinical observations
   (e) Absence of signs and symptoms of too large an agonist dose after an interval adequate for the client to develop complete tolerance to the blocking dose
3. Subject to a process which shall be established by the Program to address individuals who are objectively intoxicated or who are experiencing other problems that would render the administration of methadone unsafe.

K. The Program shall have a written policy for Split Dosing that must:

1. Include input from the Medical Director in consultation with the treatment team and the SOTA;
2. Accurately reflect that split dosing is guided by outcome criteria that shall include:
   (a) The client complains that the dosage level is not holding.
   (b) The client exhibits signs and symptoms of withdrawal.
   (c) The Medical Director employs peak and trough criteria for split dosing, if appropriate.
   (d) The Medical Director is unable to obtain a peak and trough ratio for 2.0 or lower, increasing intervals of dosing may be appropriate.
   (e) Addressing the failure of all avenues of stabilization
   (f) Addressing stabilization failures with the client involving the Medical Director and treatment team
3. Include provisions for education of the client on the rationale for split dosing and Take-Home medication.

L. The Program shall develop, maintain, and document implementation of dosing policies and procedures for the provision of medication to a guest client "Guest Dosing" in a program in which the client is not enrolled that shall, at a minimum specify:

1. The client must be enrolled in his home OTP for a minimum of thirty (30) days before being eligible for a guest dose and another OTP, unless approval is obtained by the SOTA prior to enrollment as a guest.
2. The receiving program must have evidence of two (2) consecutive successful urine drug screens within a thirty (30) period prior to a client being enrolled for guest dosing, unless approval is obtained by the SOTA prior to enrollment as a guest.
3. The sending program's responsibilities include, at a minimum:
   (a) Develop a document to utilize in transmitting all relevant client and dosing information to the receiving agency to request guest dosing privileges;
   (b) Forward this document to the receiving program;
   (c) Provide the client with a copy of the document that was sent to the receiving program;
   (d) Verify receipt of the information sent to the receiving program;
   (e) Verify that the client understands all stipulations of the guest dosing process including, but not limited to, fees, receiving program contacts, dosing times and procedures;
   (f) Accept the client upon return from guest dosing unless other arrangements have been made; and
   (g) Document all procedures implemented in the guest dosing process in each client's case record.

4. The receiving program's responsibilities include, at a minimum:
   (a) Verify receipt of the sending program's request for guest dosing privileges and acceptance or rejection of the client for guest medication within forty-eight (48) hours of the request;
   (b) Communicate any requirements of the receiving program that have not been specified on the document submitted by the sending program;
   (c) Establish a process for medical personnel to verify dose prior to dosing; and
   (d) Document all procedures implemented in the guest dosing process in each client's case record.
5. If guest dosing exceeds fourteen (14) days, a drug screen shall be obtained.
6. Guest dosing shall not exceed twenty-eight (28) days.

L. No dose of methadone in excess of 120 milligrams may be ordered or administered without the prior approval of the SOTA.

M. Take-Home Privileges. The Program must develop, maintain, and document implementation of policies and procedures that govern the process utilized by the Medical Director and treatment team for determination of unsupervised consumption of medication, referred to as Take-Home Privileges. All information utilized to determine Take-Home Privileges must be documented in the individual's record, with documentation to include at a minimum, the following:

1. Absence of recent abuse of drugs and/or failed urine drug screens;
2. Regularity of clinic attendance;
3. No observed, reported, or otherwise known serious behavioral problems;
4. Absence of known recent criminal activity;
5. Stability of client's home environment and social relationships;
6. Length of time in treatment;
7. Assurance that take-home medication can be safely stored within the client's home;
8. Client possession of a secure locking storage device in order to receive the medication from the clinic (NO exceptions); and
9. Decisions and rationale for the approval of Take-Home Privileges.

P. The program will adhere to the following schedule of Treatment Phases based on the clinical judgment of the Medical Director and the treatment team's behavioral assessment of the individual served. The quantity of take-home medication and frequency of urine drug screens (UDS) must not be less restrictive than the following:

7. Phase 1 - During the first ninety (90) days of treatment, clients will successfully complete a minimum of two (2) UDSs pre month but will NOT be eligible for any take-home medication.
8. Phase 2 – During days 91-180 of treatment, clients will successfully complete one (1) UDS per month to be eligible for two (2) doses per week of take-home medication.
9. Phase 3 – During days 181-270 of treatment, clients will successfully complete one (1) UDS per month to be eligible for three (3) doses per week of take-home medication.
10. Phase 4 – During days 271-365 of treatment, clients will successfully complete one (1) UDS per month to be eligible for six (6) doses per week of take-home medication.
11. Phase 5 – During the second continuous year of treatment, clients will successfully complete one (1) UDS per month to be eligible for thirteen (13) doses of take-home medication.
12. Phase 6 – during the third and subsequent continuous years of treatment, clients will successfully complete one (1) UDS per month to be eligible for a one (1) month supply of take-home medication.

Q. Temporary Take-Home Medication for non-emergency: The Program shall develop, maintain, and document implementation of written policies and procedures for the process to allow for temporary take-home medication for exceptional circumstances which shall include at a minimum:
   1. The need for temporary take-home medication shall be clearly documented with verifiable information in the clinical record.
   2. Client will meet the minimum requirements for Take-Home Privileges outlined in section 59.4G;
   3. Assessed and authorized, as appropriate, for a Sunday, or legal holiday as identified by Section 3-3-7, Mississippi Code of 1972, Annotated (Amended in regular Session 1987, effective from and after passage March 20, 1987.);
   4. Not allowed in short-term detoxification; and
   5. Requests for temporary special take-home medication shall be approved in writing by the State Opioid Treatment Authority prior to dispensing and administering medication to the client.

R. Temporary Take-Home Medication for emergency: The Program shall develop, maintain, and document implementation of written policies and procedures for the process to allow for temporary take-home medication for exceptional circumstances which shall include at a minimum:
   1. The need for emergency take-home medication shall be clearly documented with verifiable information in the clinical record.
   2. Requests for emergency take-home medication shall be approved in writing by the Program's Medical Director and shall not exceed a three (3) day medication supply at any one (1) time;

3. Requests for emergency special take-home medication shall be approved in writing by the SOTA prior to dispensing to the client.
4. Situations that might warrant emergency take-home medication include:
   (a) Death in the family;
   (b) Illness;
   (c) Inclement weather;
   (d) Other similar uniquely identified situations
5. Not allowed in short-term detoxification

S. Since the use of take-home privileges provides opportunity not only for diversion, but also accidental poisoning, the medical director~~/physician~~ and the treatment team must make every attempt to ensure that the Take-Home Medication is given only to individuals who will benefit from it and who have demonstrated responsibility in handling methadone. The program must have a written policy with documentation of implementation of a "call-back" procedure requiring a random schedule or with reasonable cause that the patient be required to return to the program with the amount of medication that should be remaining based upon prescribed dosing.

~~J. The Opioid Treatment Program can only consider exceptions of the Take-Home Medication Policy only under the following conditions:~~

~~1. When the individual is found to have a physical disability which interferes with his/her ability to conform to the applicable mandatory schedule, the patient may be permitted a temporary or reduced schedule, provided the patient is also responsible in handling narcotic drugs;~~
~~2. When an individual, because of exceptional circumstances such as illness, personal or family crisis, travel, or other hardship, is unable to conform to the applicable mandatory schedule. The rationale for this exception must be based on the reasonable clinical judgment of the program's medical director/physician, which must be documented in the individual's record; and/or~~
~~3. If the program is not in operation due to the observance of an official state holiday, individuals may be permitted one extra take home dose and one fewer program visit per week on the day in which the holiday occurs. An official state holiday is the day on which state agencies are closed and routine state government business is not conducted.~~

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.6 ~~59.5~~ Withdrawal Management

A. Medically supervised withdrawal management from a synthetic narcotic with a continuum of care must be a part of the treatment protocol for the Opioid Treatment

Program. The program must ~~have~~ develop, maintain, and document implementation of written policies and procedures that ~~address~~ include, at a minimum:

11. A process for voluntary medically supervised withdrawal that shall:
    (a) Acknowledge that participation in the OTP is voluntary and that the client is free to leave treatment at any time;
    (b) Identify the steps to be taken by the program when a client and program staff agree on a need to initiate the withdrawal procedures;
    (c) Identify the steps to be taken by the program when a client requests withdrawal against the medical advice of the program staff; and
    (d) Ensure availability of a variety of supportive options to improve the chances of a successful episode of medically supervised withdrawal.
12. A process for involuntary medically supervised withdrawal that shall:
    (a) Identify the circumstances under which involuntary administrative withdrawal procedures will be implemented;
    (b) Identify the steps to be taken to delineate the responsibilities of program staff in implementation of involuntary administrative withdrawal procedures;
    (c) Ensure availability of a variety of supportive options to improve the chances of a successful episode of medically supervised withdrawal; and
    (d) Provide for the referral or transfer of the client to an appropriate treatment program upon completion of the withdrawal process.
13. The program Medical Director shall approve all requests for voluntary and involuntary withdrawal from OTP.
14. The Medical Director shall establish an individual withdrawal dosage schedule in accordance with sound medical treatment and ethical considerations, and based on an objective assessment of each client's unique needs.
15. Each individual withdrawal schedule shall be for a time period of not less than thirty (30) days, unless otherwise clinically contraindicated with supporting documentation from the Medical Director.
16. Take-home medication shall NOT be allowed during medically supervised withdrawal.
17. A history of one (1) year of physiological dependence shall not be required for admission to an OTP for supervised withdrawal.
18. Clients who have two (2) or more unsuccessful detoxification episodes within a twelve (12) month period shall be assessed by the program Medical Director for other forms of treatment.
19. A program shall not admit a client for more than two (2) detoxification episodes in one (1) year.
20. Drug screens during detoxification shall be performed as follows:
    (a) An initial drug screen shall be performed at the beginning of the detoxification process.
    (b) At least one (1) random drug screen shall be performed monthly during the detoxification process.

15. Decreasing the dose of the synthetic narcotic to accomplish gradual, but complete withdrawal, within the tolerance level of the individual;

16. Counseling of the type and quantity designed to motivate the continuation of the withdrawal process;
17. Assurance that voluntary withdrawal would be discontinued and maintenance resumed in the event of impending relapse; and
18. Provisions for the continuance of care after the last dose of methadone.

B. Documentation must be maintained regarding the individual's condition during the total withdrawal process to include:

4. Signs and symptoms of medical and emotional distress;
5. Actions taken to avoid discharge; and
6. Progress of the individual served.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.7 ~~59.6~~ Diversion Control

A. The Program must develop, maintain and document implementation of a written plan ~~must be maintained~~ to ~~address Diversion Control. The program must demonstrate accountability and efficiency in reducing~~ reduce the possibilities for diversion of controlled substances from legitimate treatment to illicit use. The diversion control plan must include, at a minimum, policies and procedures for:

1. Continuous monitoring of clinical and administrative activities ~~to~~ related to dosing and take-home dispensing practices to identify weaknesses and reduce the risk of medication diversion;
2. Problem identification and correction, including for prevention of related diversion problems;
3. ~~Demonstrating~~ Specific assignment of diversion control measures to staff members who are identified in the diversion control plan to demonstrate accountability to patients and the community;
4. Random and unannounced drug screening for all employees, including full-time or contract employees;
5. Video-camera surveillance in medication area(s), both within the dispensing area and outside the dispensing area with all monitoring conducted by the administrator and/or security personnel;
6. Surveillance in the parking lot of the clinic and surrounding areas, including security camera(s) with outdoor monitoring capabilities; and,
7. Loitering by individuals being served around the building and surrounding area(s) is not permitted.
8. Procedures for clients who are dispensed there (3) or more take-home doses to receive a minimum of two (2) call-backs annually;

9. Restriction of employees from taking purses or bags into the medication area(s); and
10. Only one client at a time at the medication window;

~~1. Restriction of employees from taking purses or bags into the medication area(s);~~
~~2. Restriction of activities in medication area(s), area(s) for preparation, administration, and dispensing of medications.~~

~~B. The Opioid Treatment Program must have written policy and procedures specifically for individuals that ensure the following:~~

~~1. Only one individual at a time at the medication window;~~
~~3. 2. Implementation of a call-back program for patients to bring their take-home medications back to the clinic to check how many remaining doses are left;Surveillance in the parking lot of the clinic and surrounding areas, including security camera(s) with outdoor monitoring capabilities; and,~~
~~Loitering by individuals being served around the building and surrounding area(s) is not permitted.~~

D. The Opioid Treatment Programs must have written procedures for handling bio hazardous medical waste material, which provide at a minimum the following:

1. Safe handling;
2. Safe storage; and
3. Safe disposal.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Rule 54.8 ~~59.7~~ Multiple Enrollments

E. The Program shall develop, maintain and document implementation of written policies and procedures established to ensure that it does not admit or provide medication for an individual who is enrolled in another OTP. The policies and procedures shall include the following at a minimum:

F. The SOTA shall establish written guidelines, incorporated herein by reference, for participation in a central registry process to aid in the prevention of multiple enrollment of a client in more than one OTP at the same time. Each OTP Program shall provide written documentation of adherence to the SOTA guidelines that shall, at a minimum, include the following:

7. The Program shall make a disclosure to the central registry at each of the following occurrences:
   (d) A client is admitted for opioid treatment;
   (e) A client is transferred to another provider for opioid treatment;
   (f) A client is discharged from opioid treatment;
8. Program shall make disclosures in the format and within the timeframes established by the SOTA.
9. Program shall limit disclosures to client identifying information and the dates of admission, transfer, and discharge.
10. Program shall obtain the client's written consent, in accordance with 42 CFR Part 2, prior to making any disclosures to the central registry.
11. Program shall inform each client of the required written consent for participation in the central registry before services are initiated.
12. Program shall deny admission to individuals who refuse to provide written consent for disclosures to the central registry and shall document these denials in the case record.

G. The Program shall obtain the client's written consent, in accordance with 42 CFR Part 2, to photograph the applicant at the time of admission. The photograph shall be maintained in the client's case record.

H. The Program shall require that all clients show proof of identification in the form of an official state driver's license or a non-driver's license issued by the state's Department of Public Safety. A copy of current identification will be maintained in the clinical record.

Source: Section 41-4-7 of the *Mississippi Code, 1972, as amended*

Part 2: Chapter 56: Glossary

A. Basic bedroom furnishings – bed frame, mattress (at least 4 inches thick), box springs (if applicable to bed frame type), night stand, chest of drawers or dresser, lamp, nightstand, 2 sets of bed linens

B. Certified Peer Support Specialist (CPS) - CPS provide non-clinical peer support that is person-centered and recovery/resiliency focused. CPS is a self-identified consumer/family member (past or present) of mental health services who has successfully completed the Department of Mental Health approved Certified Peer Specialist training and certification exam.

C. Chemical restraint - a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.

D. Community-based - services and supports are located in or strongly linked to the community, in the least restrictive setting supportive of an individual's safety and treatment needs. Services and supports should be delivered responsibly and seamlessly where the person lives, works, learns and interacts.

E. Cultural Competency - the acceptance and respect for difference, continuing self-assessment regarding culture, attention to dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of minority populations.

F. Days - calendar days.

G. Director – an individual with overall responsibility for a service or service area. This individual must have at least a Master's degree in a mental health or related field and (1) a professional license or (2) DMH Credentials as a Mental Health Therapist or DMH credentialed Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served and/or supervised).

H. DMH Credentials – examples include Certified Mental Health Therapist (CMHT), Certified Intellectual or Developmental Disabilities Therapist (CIDDT).

I. Grievance - a written statement made by an individual receiving service alleging a violation of rights or policy.

J. Immediate family members - spouse, parent, stepparent, sibling, child, or stepchild.

K. Legal representative – the legal guardian or conservator for an individual as determined in a court of competent jurisdiction.

L. Mechanical restraint - the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

M. Medical Screening - Components of medical screening include: patient personal information, doctor's information (name, etc.), exam information – BP, pulse, height, weight, current diagnosis, current meds, statement of freedom from communicable disease, physical and dietary limitations and allergies. Must be signed by a licensed physician/nurse practitioner.

N. Peer - A self-identified consumer or family member of a consumer of mental health services.

O. Peer Support Service - Peer Support Services are person-centered activities that allow consumers/family members the opportunity to direct their own recovery and advocacy processes. Peer Support is a helping relationship between peers and/or family member that is directed toward the achievement of specific goals defined by the individual. Peer Support Services include a wide range of structured activities to assist individuals in their individualized recovery/resiliency process. Specific goals may include the areas of wellness and recovery/resiliency, education and employment, crisis support, housing, social networking, development of community roles and natural supports, self-determination and individual advocacy.

P. Peer Support Supervisor - An individual credentialed according to the standards and guidelines determined by DMH. Prior to, or immediately upon acceptance in a Peer Support Supervisory position, this individual will be required to receive basic Peer Specialist training specifically developed for supervision within the Peer Specialist program, as provided by DMH.

Q. Person Centered Planning – A best practice approach to planning for people who require life-long supports and services. Person Centered Planning discovers and acts on what is important to a person as well as what is important for a person. Person Centered Thinking© principles are used to gather information with and from participants of the person's choosing. The person and his/her team develop individually tailored outcomes that are molded into activities to assist people in having meaningful days and in doing what they choose to do.

R. ~~R.~~ Person-Centered, Recovery Oriented System of Care ~~process~~ – identification of the supports needed for individual recovery and resilience. Individualized and person-centered means that the combination of services and supports should respond to an individual's needs, and should work with the strengths unique to each individual's natural and community supports. Services and supports should be designed to help the person served identify and achieve his/her own recovery goals. The public mental health system must also recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation. However, an

individualized/person-centered process must recognize the importance of the family and fact that supports and services impact the entire family.

S. Person Centered Thinking – Person Centered Thinking underlies and guides respectful listening which leads to actions, resulting in people who: Have positive control over their life; are recognized and valued for their contributions (current and potential) to their communities; and are supported in a web of relationships, both natural and paid, within their communities. © TLC-PCP

T. ~~S.~~ Physical escort - the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.

U. ~~T.~~ Physical restraint - personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.

V. ~~U.~~ Professional License – examples include Licensed Professional Counselor (LPC), Licensed Psychologist, Licensed Master Social Worker (LMSW), Licensed Certified Social Worker (LCSW), Licensed Marriage and Family Therapist (LMFT), and Medical Doctor.

W. ~~V.~~ Program - the single service provision site.

X. ~~W.~~ Provider - the overall agency/entity. Provider does not refer to an individual staff member or program site.

Y. ~~X.~~ Psychiatric Services – includes interventions of a medical nature provided by medically trained staff to address medical conditions related to the individual's mental illness or emotional disturbance. Medical services include medication evaluation and monitoring, nurse assessment, and medication injection.

Z. ~~Y.~~ Results-oriented - services and supports that lead to improved outcomes for the person served. People have as much responsibility and self-sufficiency as possible, taking into consideration their age, goals and personal circumstances. Recovery- oriented services means services that are dedicated to and organized around actively helping each individual served to achieve full personal recovery in their real life and service environment.

AA. ~~Z.~~ Seclusion - a behavior control technique involving locked isolation. Such term does not include a time-out.

BB. ~~AA.~~ Supervisor - an individual with predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services for such areas as Work Activity Services, Day Services-Adults, Psychosocial Rehabilitation Services, Day Support Services, etc. This individual must have at least a Bachelor's degree in a Mental Health, Intellectual/Developmental Disabilities, or a related field, and be under the

supervision of an individual with a Master's degree in a Mental Health, Intellectual/Developmental Disabilities, or a related field.

CC. ~~BB.~~ Time Out - behavior management technique which removes an individual from social reinforcement into a non-locked room, for the purpose of calming. The time-out procedure must be part of an approved treatment program.