Operational Standards
for
Mental Health,
Intellectual/Developmental Disabilities,
and Substance Abuse
Community Service Providers

2011 Revision
Effective January 1, 2011

Mississippi Department of Mental Health
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STATUTORY AUTHORITY

The Mississippi Department of Mental Health (hereafter referred to as "DMH") is the state agency charged with administering the public system of mental health, intellectual/developmental disabilities, substance abuse, and Alzheimer's Disease and Other Dementia Services. The agency was created in 1974 by an Act of the Mississippi Legislature, Regular Session. The creation, organization and duties of the DMH are defined under Section 41-4-1 through 41-4-27.

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

- supervise, coordinate, and establish standards for all operations and activities of the state, related to mental health and providing mental health services (Section 41-4-7 (c));

- 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 (Section 41-4-7 (f)); and,

- 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 (See Section 41-4-7(g)).

Scope

The Mississippi Department of Mental Health *Operational Standards for Mental Health. Intellectual/Developmental Disabilities and Substance Abuse Community Service Providers* serves as the standards/minimum standards referred to in Section 41-4-7 (c), Section 41-4-7 (f) and Section 41-4-7 (g) mentioned above. This revision of standards will be effective January 1, 2011.

MISSION

The mission of the DMH is supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems, and intellectual or developmental disabilities one person at a time.

VISION

We envision a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports.

A better tomorrow exists when…

- All Mississippians have equal access to quality mental health care, services and supports in their communities.
- People actively participate in designing their services.
- The stigma surrounding mental illness, intellectual/developmental disabilities, substance abuse and dementia has disappeared.
- Research, outcome measures, and technology are routinely utilized to enhance prevention, care, services and supports.

PHILOSOPHY

The DMH is committed to developing and maintaining a comprehensive, statewide system of prevention, service, and support options for adults and children with mental illness or emotional disturbance, with alcohol/drug problems, and/or intellectual or developmental disabilities, as well as adults with Alzheimer's disease and other dementia. The Department supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. DMH strives to provide a network of services and supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. DMH is committed to preventing or reducing the unnecessary use of inpatient or institutional services when individuals' needs can be met with less intensive or least restrictive levels of care as close to their homes and communities as possible. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

VALUES AND GUIDING PRINCIPLES

People We believe people are the focus of the public mental health system. We respect the dignity of each person and value their participation in the design, choice and provision of services to meet their unique needs.

Community We believe that community-based service and support options should be available and easily accessible in the communities where people live. We believe that services and support options should be designed to meet the particular needs of the person.

Commitment We believe in the people we serve, our vision and mission, our workforce, and the community-at-large. We are committed to assisting people in improving their mental health, quality of life, and their acceptance and participation in the community.

Excellence We believe services and supports must be provided in an ethical manner, meet established outcome measures, and be based on clinical research and best practices. We also emphasize the continued education and development of our workforce to provide the best care possible.

Accountability We believe it is our responsibility to be good stewards in the efficient and effective use of all human, fiscal, and material resources. We are dedicated to the continuous evaluation and improvement of the public mental health system.

Collaboration We believe that services and supports are the shared responsibility of state and local governments, communities, family members, and service providers. Through open communication, we continuously build relationships and partnerships with the people and families we serve, communities, governmental/nongovernmental entities and other service providers to meet the needs of people and their families.

Integrity We believe the public mental health system should act in an ethical, trustworthy, and transparent manner on a daily basis. We are responsible for providing services based on principles in legislation, safeguards, and professional codes of conduct.

Awareness We believe awareness, education, and other prevention and early intervention strategies will minimize the behavioral health needs of Mississippians. We also encourage community education and awareness to promote an understanding and acceptance of people with behavioral health needs.

Innovation We believe it is important to embrace new ideas and change in order to improve the public mental health system. We seek dynamic and innovative ways to provide evidence-based services/supports and strive to find creative solutions to inspire hope and help people obtain their goals.

Respect We believe in respecting the culture and values of the people and families we serve. We emphasize and promote diversity in our ideas, our workforce, and the services/supports provided through the public mental health system.

PART I

PROCEDURES FOR CERTIFICATION

Providers seeking DMH certification of any type must follow procedures outlined in this Part and its subsequent Sections A-L. In order to be certified by the Mississippi DMH, the provider must have sufficient safeguards in place to assure that all program components operate in an ethical, moral, legal and professional manner. This requirement includes training of all program staff and volunteers (executive level down) regarding the ethical treatment of individuals served by the program, as well as proper use of program and individual funds/grants.

SECTION A - CERTIFICATION OPTIONS

Service provider organizations seeking certification or recertification by the Mississippi DMH are categorized in these standards by designations related to such factors as their status as a governmental/nongovernmental entity, source of funding, and/or statutory and other regulatory requirements governing certification. Applicants must indicate on the Application for Certification form (pp. 14-15) the designated option under which they are seeking certification. Programs with certain designations may be charged a fee for certification. (Refer to Section B-Fees, which follows.)

NOTE: 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.

NOTE: Certification by the Mississippi DMH of any type is not a guarantee of designation as a DMH designated Community Mental Health/Intellectual Disability Center.

Providers seeking certification or recertification that meet all application procedure requirements and Operational Standards herein will receive a Certificate of Operation, valid for a period of three (3) years with one of the following designations:

1. 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 programs, 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. These programs must follow procedures in Part I and meet <u>all</u> standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

2. DMH/CMHC (DMH/C): Programs 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. These programs must follow procedures in Part I and meet all standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

3. DMH/Grants (DMH/G): Programs 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 programs that receive funds directly from the DMH, but that are not community mental health centers (DMH-C designation) or DMH-operated programs (DMH/D designation). These programs must follow procedures in Part I and meet all standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

4. DMH/Home and Community-Based Waiver (DMH/H): Programs meeting requirements for certification to provide services under the Home and Community-Based Services-ID/DD Waiver must be certified. Programs/agencies that may apply include those already certified by the DMH as well as other agencies that provide the type services offered through the HCBS Waiver. These programs must follow procedures in Part I and meet all standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

5. DMH/Other Agency Requirement or Option (DMH/O): Private nonprofit and private for-profit programs 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 programs will be designated as DMH/O programs.

   All other providers seeking certification by the DMH which are not designated under the DMH/D, DMH/C, DMH/G, or DMH/H options will be designated as DMH/O programs. These include those programs without external requirements for certification by the DMH that seek certification voluntarily, such as for additional assurance to the public that they meet State Operational Standards for provision of services.

   These programs must follow procedures in Part I and meet all standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

   Providers seeking certification required by the Mississippi Department of Finance and Administration for service provision under the State Employee Health Insurance Plan

must meet state qualifications set forth in the Plan. These programs must follow procedures in Part I and meet all standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

SECTION B - FEES

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.

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

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.

SECTION C - MINIMUM REQUIRED SERVICES

I.C. The DMH's philosophy supports making available to Mississippians a continuum or array of treatment and support services that are accessible on a statewide basis. Establishment of minimum required services is necessary to develop a comprehensive system of care.

I.C.1. Community Mental Health Centers operated 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 DMH requirements of and are determined necessary by DMH to be a designated and approved mental health center (DMH/C) must provide the following minimum services throughout the CMHC's entire catchment area:

a. Adult Mental Health Services

(1) Outpatient Therapy
(2) Case Management
(3) Psychiatric/Physician Services
(4) Emergency/Crisis Services
(5) Psychosocial Rehabilitation
(6) Inpatient Referral
(7) Support for Family Education Services
(8) Support for Consumer Education Services
(9) Pre-Evaluation Screening for Civil Commitment (required only for centers operated by regional commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*)

b. Children and Youth Mental Health Services

(1) Day Treatment
(2) Outpatient Therapy
(3) Case Management
(4) Psychiatric/Physician Services
(5) Intake/Functional Assessment
(6) Emergency/Crisis Services
(7) Pre-Evaluation Screening for Civil Commitment (for youth age 14 and over)

c. Alcohol and Drug Abuse Services

(1) Outpatient Therapy
(2) Primary Residential Treatment (adults)
(3) DUI Assessment
(4) Outreach/Aftercare
(5) Prevention Services

d. Intellectual/Developmental Disabilities Services

(1) Case Management
(2) Emergency/Crisis Services

SECTION D - APPLICATION FOR CERTIFICATION GUIDELINES

I.D.1. Initial Application Process:

a. All applicants for initial certification must submit a completed Application for Certification form, including any attachments as indicated. Refer to application forms/attachments in Part I, Standard I.D.3. Application Forms that follow.

b. Application forms, attachments and any required fees must be submitted to the Division of Accreditation and Licensure.

c. The Department may request additional information during review of the application. After reviewing the application, the DMH will notify the applicant within thirty (30) days whether or not the application is acceptable and whether or not the certification process can proceed.

d. All inquiries regarding certification should be directed to the Division of Accreditation and Licensure.

e. Upon written request, the DMH may provide technical assistance to the applicant preparing for certification.

f. Prior to the completion of the application process, all applicants seeking certification, except those to be designated as DMH/D and DMH/C providers established under the Regional Commission Act (Section 41-19-31 et seq., *Mississippi Code 1972, Annotated*), must be incorporated in Mississippi and have an established office physically located in Mississippi.

If the application is complete to include all required documentation, the certification process continues as described in Standard I.E.4.

Providers denied certification/recertification by the DMH may reapply for certification in accordance with Part I, Sections D and E. Providers may apply for certification/recertification only twice during a twelve (12) month period.

I.D.2. Application Process for Requesting Additional Services:

a. Applicants that currently hold valid certification by the DMH for some services and are applying for certification of additional or different types of services must submit an Application for Certification form, indicating on the form that

the application is for additional services. This form, with any attachments as indicated, must be submitted to the Division of Accreditation and Licensure

b. Applicants currently holding valid certification by the DMH for a particular service at a particular site and service location that seek to open an additional or new program at the same site or physical location or at a different site or physical location must submit a separate Application for Certification Form for each new or additional program.

c. A separate application is required for each program, since staffing and physical facilities/environment/safety issues could potentially be different for each new or additional program, even if they are located in the same building.

d. For any program that is closed at one site and plans are to subsequently open or reopen a program at a different site, the program that is to be opened or reopened shall be considered a new or additional program. Therefore, in such cases, the provider must submit an Application for Certification Form for each new or additional program, even if the new or additional program is anticipated to serve some or all of the same individuals served in the closed program

e. The Department may request additional information during review of the application. After reviewing the application, the DMH will notify the applicant within thirty (30) days whether or not the application is acceptable and whether or not the certification process can proceed.

If the application is complete to include all required documentation the certification process continues as described in Standard I.E.4.

Providers denied certification/recertification by the DMH may reapply for certification in accordance with Part I, Sections D and E. Providers may apply for certification/recertification only twice during a twelve (12) month period.

I.D.3. <u>Application Forms:</u>

a. DMH Application for Certification.

DMH
APPLICATION for CERTIFICATION

☐ INITIAL CERTIFICATION
☐ CERTIFICATION OF ADDITIONAL SERVICES

NAME OF PROVIDER SEEKING CERTIFICATION:_____

ADDRESS: _____

CONTACT PERSON: _____ PHONE NUMBER:_____DATE: ___/___/___

CERTIFICATION REQUESTED: ☐ DMH/D ☐ DMH/C ☐ DMH/G ☐ DMH/H ☐DMH/O

PLEASE COMPLETE THE FOLLOWING **IN DETAIL.** ATTACH PAGES AS NECESSARY.

I. IDENTIFY THE SERVICE(S) FOR WHICH CERTIFICATION IS REQUESTED. *(REFER TO SERVICE TITLES IN **PARTS VIII-XVIII** OF THESE STANDARDS.)*

_____
_____
_____

II. DESCRIBE THE SERVICE(S)

A. Describe the program design and days/hours of operation in detail. Attach pages as necessary.

_____
_____
_____

B. Location (Include a floor plan.)
Physical Address: ☐ **Same** ☐ **Different** from above. If different, provide address at which program is to be located.

_____
_____

Do other DMH-certified programs exist at address listed above? ☐ **Yes** ☐ **No** If yes, provide Certificate #s for each program:

_____
_____

C. Staffing, by position and title (Attach job description(s) including minimum qualifications.)

_____
_____
_____

D. Description of individuals to be served in each service (such as, diagnostic categories, ages, number to be served.) Programs providing a service to more than one population (i.e., mental health, intellectual disability, etc.) must clearly indicate the number to be served for each population. For child/adolescent Day Treatment, also include a copy of each child's Individual Service Plan.

_____
_____
_____

E. Geographic area to be served (state, county, city, etc.) For child/adolescent mental health Day Treatment, also provide school district to be served.

_____

_____
F. Attach any permits, inspections, etc. required to operate the facility. (See Part VII, Standard VII.ES.1.)
G. Provide information on the legal status of the applicant organization (private non-profit, private for profit, public, etc.). Attach a copy of the applicable section of the *Mississippi Code of 1972, Annotated*, or a copy of other legal documents that clearly establish the applicant's status including at least the Mississippi Charter of Incorporation. The sponsoring organization must be incorporated in Mississippi and have established an office (physical location) within the boundaries of Mississippi. Also, a copy of the applicant's organizational by-laws must be attached.

_____

NAME OF EXECUTIVE OFFICER OF APPLICANT ORGANIZATION (TYPED)

_____ _____

SIGNATURE OF EXECUTIVE OFFICER **DATE**

Mail completed application, attachments, and any required fees to the Division of Accreditation and Licensure.

DIVISION OF ACCREDITATION & LICENSURE
1101 ROBERT E. LEE BUILDING
239 NORTH LAMAR STREET
JACKSON, MISSISSIPPI 39201
(601) 359-1288
FAX NUMBER

FOR DMH USE ONLY

	DATE	INITIALS				
REVIEWED (DIVISION)						
REVIEWED (BUREAU)						
COMMITTEE APPROVAL						

SECTION E - CERTIFICATION PROCESS

I.E.1. All services, programs and sites of service delivery (i.e. satellite offices, supervised living programs, and residential programs) must be certified prior to delivery of services and remain certified in order to continue service provision.

I.E.2. Certification is for a period of three (3) years. During the three (3) year period, the DMH will review all certified providers/programs at intervals deemed necessary by DMH. During the three (3) year certification period, providers will be required to complete a DMH-approved self assessment identifying areas of concerns and a plan to address these areas.

I.E.3. Criteria for programmatic certification includes:

a. Provision of applicable required services in all required locations for desired certification option;

b. Adherence to DMH standards, guidelines, contracts, memoranda of understanding, and memoranda of agreement;

c. Fiscal compliance with DMH fiscal management standards and practices;

d. Evidence of fiscal compliance/good standing with external (other than DMH) funding sources; and

e. Compliance with ethical practices/codes of conduct of professional licensing entities related to provision of services.

I.E.4. Initial Application/Certification of New or Additional Services includes the following:

a. An application for certification must be submitted to the Division of Accreditation and Licensure and found acceptable by DMH Review Committee before an on-site visit can occur.

b. If application is found acceptable, the Division of Accreditation and Licensure will contact the applicant and schedule an on-site visit.

c. Prior to the on-site visit, DMH may conduct a desk review of the following information:

(1) Policies and Procedures manual

(2) Staffing plan, including qualifications
(3) Record of staff training
(4) Description of program site (inclusive of floor plan)
(5) For applicants requesting certification of Children/Youth Day Tx programs, applicants must submit the Individual Service Plan for all children/youth participating in the program. DMH must be able to identify the individual responsible for diagnosis and certification of treatment.

d. In addition to a satisfactory on-site certification visit, applicants must be found to be in compliance with all DMH criteria for certification.

e. If an applicant is found to be in compliance with all DMH criteria for certification and on-site visit, the applicant will be issued a Certificate of Operation within thirty (30) calendar days of completion of the on-site visit.

f. Certificates of Operation are valid for three (3) years. Prior to the end of the three year certification period, the DMH will conduct recertification.

g. Providers/agencies requesting initial certification or certification of additional services cannot seek reimbursement for the service/program until there is a valid Certificate of Operation.

h. For DMH/H providers, DMH will notify DOM of certification status. The applicant/provider will be responsible for applying for a DOM provider number in order to render and claim reimbursement for ID/DD waiver services.

i. DMH/H providers will not be able to claim reimbursement for ID/DD Waiver services before they are assigned a Mississippi Medicaid provider number specifically for ID/DD Waiver services and receive a DMH Certificate of Operation.

DMH Review and Written Reports of Findings

I.E.5. Should deficiencies be found during the on-site visit and/or DMH desk review, the Division of Accreditation and Licensure will issue a written report of findings within ten (10) calendar days of the last day of the on-site visit to the Executive Director of the agency seeking certification.

a. The DMH Written Report of Findings will inform the provider that there is a determination of noncompliance with requirements for certification. The provider is informed that termination of certification will be

effective within ninety (90) calendar days from the last day of the on-site visit (whether or not the provider chose to participate in an exit interview with DMH staff). The termination date will be included in the written report.

b. Prior to termination, the provider has the opportunity to achieve compliance with certification requirements.

Plan of Compliance

I.E.6. If found to be in noncompliance with criteria for certification, the Executive Director of the agency must submit a plan of compliance to the Division of Accreditation and Licensure within ten (10) days from the date of the DMH written report.

a. Challenges to the validity of the written report of findings (including specific deficiencies) will not be considered acceptable.

b. If the plan of compliance is found to be acceptable, DMH will notify the agency within ten (10) days of the date of the plan of compliance. A follow-up visit will be scheduled within sixty (60) days from the last day of the on-site visit to determine compliance or that an acceptable level of progress has been achieved.

c. If the plan of compliance and follow-up visit is satisfactory, DMH will notify the provider/agency in writing that the plan of compliance and follow-up visit were satisfactory and the termination process will cease.

d. If the plan of compliance is not acceptable, DMH will notify the agency within ten (10) days of the date of the plan of compliance that the plan is not acceptable. The termination of certification process will continue.

Termination of Certification

I.E.7. If no acceptable plan of compliance is achieved, termination of certification will be effective ninety (90) calendar days from the last day of the on-site visit (as identified in the DMH Written Report of Findings).

a. DMH will notify applicable funding sources of the possible termination within fifteen (15) days prior to the termination date.

b. On the identified termination date, termination takes effect if compliance is not achieved.

Criteria for DMH Administrative Suspension or Termination of Certification

I.E.8. A determination that the certification status may be reduced, suspended or revoked shall be made upon any of the following criteria:

a. Failure to comply with DMH Minimum Standards.

b. Failure to comply with guidelines, contracts, memoranda of understanding, and memoranda of agreement.

c. Failure to comply with DMH fiscal requirements.

d. Defrauding an individual receiving services, individual that may potentially receive services and/or third party payer sources.

e. Endangerment of the safety, health, and or the physical or mental well-being of an individual served by the agency/program.

f. Inappropriate and/or unethical conduct by program staff or its governing authority.

g. Any other just cause as identified by the MS State Board of Mental Health/ DMH Executive Director.

I.E.9. Determinations to initiate proceedings for DMH Administrative Suspension or Termination of Certification are made by the DMH Executive Director or his designee.

a. The DMH Administrative Suspension or Termination of Certification may follow the same timelines as established for compliance/noncompliance with programmatic certification criteria unless otherwise directed by the DMH Executive Director and/or MS State Board of Mental Health. Any changes in timelines will be made in writing to the provider/agency involved.

b. In cases of an emergency related to care and treatment of individuals, fiscal or budgetary emergencies or deficiencies, or other emergency situations as determined at the discretion of DMH, a certification may be changed or revoked immediately, with or without prior notice to the provider.

Recertification

I.E.10. Providers with a valid Certificate of Operation from the DMH for existing programs do not have to submit another Application for Certification form to initiate the process for recertification of those programs covered by the valid certificate.

I.E.11. A Certification Visit of the program for which recertification is required must occur before any services operated under the certificate can continue beyond the ending date on the valid Certificate. The Certificate of Operation will include beginning and ending dates for which certification is valid.

I.E.12. Before the end of the period for which the current Certificate of Operation is valid (three years), the Department Certification Review Team will make a certification visit (which may include desk review and on-site visit) to determine the provider's compliance with criteria for certification.

I.E.13. The process for recertification is the same process as outlined in Standards I.E.5. through I.E.7.

I.E.14. **Ongoing or Unresolved Fiscal or Programmatic Audits**

If it is found during the fiscal or program review process that a repayment of funds is required and this repayment has not been made within a year of notice of request for repayment, the provider cannot be certified/recertified for the service for which funds are owed. For any provider that has an ongoing and/or unresolved fiscal or programmatic audit, the Department will not certify or fund additional services for that provider, except as initiated by the DMH.

SECTION F - PEER REVIEW

I.F. All DMH funded/certified programs are subject to a DMH-approved peer review/quality assurance evaluation process that assures that appropriate assessment, diagnosis and treatment are provided according to established professional criteria and guidelines. Additionally, this process assures that services are provided in accordance with basic, generally-accepted standards of ethical and professional behavior.

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. 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.

Members of the Peer Review team include consumers of services designed to meet the needs of individuals with mental illness, intellectual or developmental disabilities, and alcohol or drug abuse disorders. Family members, mental health professionals and interested stakeholders also comprise the peer review team. Team members obtain information from peers and program staff about satisfaction with services, review programs, and dialogue with mental health administrators. The team provides feed back to providers and local advisory councils.

SECTION G – APPEAL PROCEDURES

I.G.1. Any provider applying for and/or holding certification by the DMH may appeal the following decisions and/or penalties:

a. Disapproval of Plan of Compliance.
b. Any financial penalties invoked by DMH associated with noncompliance with operational standards and/or audit findings.
c. Denial of request for a waiver of a DMH operational standard.
d. Termination of Certification.

I.G.2. Appeal procedures are as follows:

a. All appeals must be initiated by filing a written notice of appeal by certified mail in an envelope clearly marked Notice of Appeal with the DMH Executive Director and a copy to the Mississippi Department of Mental Health attorney within 10 days from the date of the final notification by the Department of Mental Health of the decision(s) being appealed (described above).

b. The written notice of appeal must have as its first line of text Notice of Appeal in bold faced 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) by the Department of Mental Health under appeal; and

(2) A statement of the relief requested.

d. The Executive Director will forward the appeal with the appropriate Bureau Director. The Bureau Director will conduct the first level of review.

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

f. If the Bureau 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 Director will specify a time line by which the additional information must be received.

g. Within 10 days of the time set by the Bureau Director for his/her receipt of the additional information requested (described in f. above), the Bureau 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 10 days of receipt of a recommendation for denial of an appeal from the Bureau 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 Bureau Director(s) 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 Bureau Director(s) to deny the appeal, the appellant may file a written request

by certified mail in an envelope clearly marked Notice of Appeal with the Executive Director's office, requesting a review of the appeal by the Mississippi State Board of Mental Health. The request must be received by the Department within five (5) 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 faced 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.

SECTION H - PROCESS FOR REQUESTING A WAIVER

I.H.1. 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 Department, in accordance with the following procedures:

a. To request a waiver of a specific standard, the provider's Executive Officer must make a written request to the Division of Accreditation and Licensure. 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; and;

(5) Specify the length of time for which the waiver is requested.

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

c. The Executive Officer of the program provider making the request will be notified of the decision within thirty (30) days of receipt of the request.

d. Appeal of the denial of requests for waivers must be in accordance with Part I, Section G - Appeal Procedures.

I.H.2. Any waivers granted under previous revisions of DMH standards are void as of January 1, 2011. Waivers should be resubmitted to DMH for review and consideration.

I.H.3. Waivers granted by DMH serve only to waive a DMH standard.

SECTION I - CERTIFICATE OF OPERATION

I.I.1. Limitations of the Certificate

a. 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 Mississippi DMH.

b. A Certificate of Operation is not transferable.

c. 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).

d. Site capacities must not exceed the number identified on the Certificate of Operation.

e. 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 Community Service Providers as established by the DMH.

I.I.2. Posting of Certificates

The original Certificate of Operation must be posted in each of the certified sites for public view. Certificates are specific to a site/building/location/name and capacities and may not be transferred to new locations. If changes are made that affect information on the certificate, the certificate must be returned to the Division of Accreditation and Licensure. If the changes do not alter certification status, a new certificate will be issued. Certificates for closed programs must be returned to the DMH within 15 days of the last day individuals were served by the provider in the program.

I.I.3. If the provider is certified for programs at multiple sites, the Department will issue:

a. A Certificate of Operation listing all the programs and services for which the provider is certified. This general certificate does not imply that all services listed can be or are provided at this primary location or at all other locations (see below). This certificate must be displayed in an area clearly visible to individuals being served by the provider in the primary or regional administrative or service building; and,

b. A Certificate of Operation for individual programs at different locations. These certificates must be displayed in an area clearly visible to people being served in the individual facility or area in which the program operates. These certificates apply to, and must be posted at, the physical address indicated on each certificate.

For example, a provider of services in multiple counties will receive a Certificate of Operation listing all the various types of programs or services provided (outpatient mental health services, children's mental health day treatment services, alcohol/drug abuse prevention services, etc.), as well as a separate Certificate of Operation for display in each program location for which the provider is certified.

SECTION J - CHANGES TO BE REPORTED TO DMH

I.J. Following certification, changes affecting the governing and/or operation of programs must be reported in writing to the Division of Accreditation and Licensure in the Mississippi DMH. 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.

I.J.1. Examples of the significant changes that must be reported before they occur include, but are not limited to:

a. Changes in the governing authority, executive and key leadership;

b. Changes in ownership or sponsorship;

c. Changes in staffing that would affect certification status;

d. Changes in program site location;

e. Increase in the capacity above that specified on the DMH certificate;

f. Changes in program scope (such as major components of a service, age ranges and/or the population served, etc.);

g. Major alterations to buildings which house the program(s);

h. Changes in operating hours; and/or,

i. Change(s) in the name(s) of the program(s) certified by the DMH.

1.J.2. Examples of significant changes that must be reported as soon as they occur include, but are not limited to:

a. Termination of operation (closure) for a period of one (1) day or more due to inclement weather or other unforeseen circumstances.

b. Termination or resignation of the governing authority member(s), Executive Officer, and key leadership.

c. Litigation that may affect service provision.

SECTION K – DMH TECHNICAL ASSISTANCE

I.K. The DMH may provide, upon written request from the program, technical assistance to applicants in meeting and maintaining requirements for certification. Additionally, other technical assistance may be provided and/or facilitated by the DMH when deemed necessary by the Department. 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).

SECTION L - ACCESS TO FACILITIES, PROGRAMS, SERVICES AND INFORMATION

I.L.1. 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.

I.L.2. DMH program and fiscal staff have authority to interview personnel individually concerning matters regarding programmatic and fiscal compliance, including follow-up on matters reported to the Department's Office of Constituency Services. Failure to comply with requests for such interviews will result in termination of the audit/review and possible discontinuance of funding.

I.L.3. When programs are visited by Peer Review/Quality Assurance Evaluation Team members, statements concerning confidentiality must be signed by all members on the team who are not DMH Employees. Visits to sites may be unannounced.

PART II

ORGANIZATION AND MANAGEMENT

All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part.

SECTION A - GOVERNING AUTHORITY

II.A.1. The provider must have documented evidence of the source of its governing authority.

II.A.2. The governing authorities of all providers must have bylaws and/or policies that:

a. 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;

b. Show documentation of the adoption of a schedule of meetings and quorum requirements;

c. Require at least quarterly meetings;

d. Provide assurance that the governing authority does not consist of employees or immediate family members (i.e. spouses and children) of employees;

e. Provide assurances that meetings of the governing authority are open to the public and include procedures for notifying the public of meetings;

f. Assure that governing authority members do not receive a per diem that exceeds the state limit.

g. Require minutes of meetings, which are to include, but not be limited to:

1. the date of the meeting;

2. names of members and other participants/visitors attending;

3. topics and issues discussed, motions, seconds and votes; and,

4. public comment.

II.A.3. The governing authority of all providers must have written documentation of the following:

a. Appointment of a 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 services and/or programs.

b. The Executive Director's authority and responsibility for the management of the program and for implementing the policies of the governing authority.

c. Completion of an annual evaluation of the Executive Director that is available for review.

d. Designation of staff positions to have authority and responsibility for all program operations in the absence of the Executive Director.

e. Establishment of an organizational structure as evidenced by an organizational chart.

II.A.4. The governing authority of all providers must review and approve at least annually the following, and document such review in the governing authority minutes:

a. Annual budget;

b. Written affiliation agreements;

c. All changes in the policies and procedures;

d. Annual Operational Plan submitted to the DMH (Except providers certified under DMH/H);

II.A.5. All certified providers must have a formal mechanism 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 the service area for which they receive services.

II.A.6. Regional Commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*, must also maintain written documentation of the following:

a. Central inventory of capital property that will include the owner, current value, and any mortgage on said property;

b. Annual cost report, developed and submitted within guidelines established by the DMH.

II.A.7. Regional Commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated,* must also 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.*

II.A.8 Regional Commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*, must also maintain written documentation of the following:

a. 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;

b. Documentation of hazard, casualty or worker's compensation insurance, as well as professional liability insurance;

c. 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;

d. Authority of the commission to provide and finance services through various mechanisms and to borrow money from private sources for such, if needed;

e. 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;

f. 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;

g. 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;

h. 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;

i. 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*), when such action affects more than one region, written prior approval by the DMH, of such action before initiation and annually thereafter;

j. 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;

k. Efforts to provide or provision of alternative living arrangements for persons with serious mental illness, including, but not limited to, group homes for individuals with serious mental illness.

SECTION B- POLICIES AND PROCEDURES MANUAL

II.B.1. There must be developed a written Policies and Procedures Manual(s) which addresses all sections and standards in Parts II-VII and for all services provided in Parts VIII-XVIII. These written policies and procedures must give details of provider/agency implementation and documentation of the DMH Operational Standards for MH/IDD/SA Community 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 program.

II.B.2. The policies and procedures manual must:

a. Be reviewed at least annually by the governing authority, as documented in the governing authority meeting minutes;

b. Be readily accessible to all staff, with a copy at each service delivery location; and

c. Describe how the manual is made available to the public.

II.B.3. 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.

SECTION C- PLANNING

II.C.1. An Annual Operational Plan must be submitted to the DMH for approval or disapproval by the date specified by DMH. (Section 41-4-7 (f) of the *Mississippi Code of 1972, Annotated*)

II.C.2. The Annual Operational Plan required in Standard II.C.1. must address, at a minimum, the Regional Community Mental Health/Intellectual Disability Commission's or other community service provider's status and plans to comply with:

a. Operational Standards for community services established by the Mississippi DMH for certification, including current status regarding compliance with DMH Operational Standards for MH/IDD/SA Community Providers, based on the most recent certification visit by the Mississippi DMH.

b. Minimum required services for certification established by the DMH for certification:

For Regional Community Mental Health/Intellectual Disability Commissions:

(1) Description of funding for each minimum service component by major funding source (federal, state, local);

(2) Targeted quantitative service levels planned for each minimum service component for the applicable fiscal year for which the Annual Operational Plan is being submitted;

(3) Targeted areas to be served;

(4) Brief narrative substantiating targeted quantitative service levels, clearly noting any increase, decrease, or maintenance in current service levels;

(5) Projected funding by major funding source (federal, state, local) for implementation of each minimum service component at targeted quantitative service levels.

For Other Community Service Providers:

(6) Current quantitative performance levels in relation to service component(s) targeted by the grant/contract and specific outcome measures for the service component(s) approved by the DMH in the signed Program Grant Award and/or Purchase of Service Contract;

(7) Funding for service components at current performance levels by major funding source (federal, state, local);

(8) Targeted performance level on outcome measure planned for each service component for the applicable fiscal year for which the Annual Operational Plan is being submitted;

(9) Brief narrative substantiating targeted performance level on outcome measure, clearly noting any increase, decrease or maintenance in current performance levels;

(10) Projected funding by major funding source (federal, state, local) for implementation of each service component at targeted performance levels or outcome measure levels.

II.C.3. The DMH will approve or disapprove the Annual Operational Plan of the Regional Mental Health/Intellectual Disability Commission and Other Community Service Providers based on minimum required standards and minimum required services established by the Department. The Department will notify the Commission/other community service provider in writing of approval/disapproval of the Annual Operational Plan. The Commission/other community service provider will receive a written Report of Review of the Annual Operational Plan, to include approval/ disapproval status. (Section 41-4-7 (f) of the *Mississippi Code of 1972, Annotated*)

II.C.4. If the Annual Operational Plan is disapproved, the DMH will include in the Report of Review of the Annual Operational Plan notification of the

disapproval and any follow-up action required, such as, but not limited to, a summary of deficiencies in the Plan and actions required for the commission/other community service provider to address these deficiencies within the probationary period. The time line(s) for any probationary period (beginning and ending dates) will be specified in the Report of Review of the Annual Operational Plan, but will not exceed six months in accordance with Section 41-4-7 (f) of the *Mississippi Code of 1972, Annotated*.

II.C.5. The governing authority of the certified provider must document in the governing authority minutes their review of the DMH Report of Review of Annual Operational Plan.

II.C.6. Within ten (10) days after the ending date of the probationary period, the Regional Commission or other community service provider must provide a written status report concerning their status on implementation of actions required by the DMH in the Mississippi Mental Health Report of Review of Annual Operational Plan.

II.C.7. If after the ending date of the probationary period, the Department determines, based on review of the status report or other information, that a Regional Commission/other community service provider still does not meet the Operational Standards and minimum required services, certification may be denied or revoked.

II.C.8. The Regional Commissions and other community service providers must submit the Annual Operational Plan and any related follow-up reports on forms (or in the format) provided or approved by the DMH.

PART III

FISCAL MANAGEMENT

III.FM. All DMH Certified Providers, regardless of type, must follow the procedures and
standards outlined in this Part.

Compliance with Operational Standards in this section will be reviewed by the DMH Fiscal Auditors.

III.FM.1. The program must prepare and maintain annually a formal, written, program-oriented budget of expected revenues and expenditures for the program that must:

a. Categorize revenues for the program by source;

b. Categorize expenses by the types of services or program components provided, and/or by grant funding;

c. Account for federal funds separately in accordance with the Single Audit Act of 1984.

III.FM.2. The fiscal management system of the program must include a fee policy that:

a. Maintains a current written schedule of rate, charge, and discount policies;

b. Is immediately accessible to individuals served by the program;

c. For residential programs, includes the development, and result in documentation, of a written financial agreement with each individual or parent/ legal guardian (of individuals under 18 years of age) entering the program that, at a minimum:

(1) 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;

(2) Is prepared prior to or at the time of admission and signed by the individual/parent/legal guardian and provided in two (2) or more copies, one (1) copy given to the individual/parent/legal guardian, and one (1) copy placed on file in the individual's record; and

(3) Does not relieve the provider of the residential program of the responsibility for the protection of the person and personal property of the individual admitted to the residential program for care.

III.FM.3. The fiscal management system of the program must:

a. 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 are not exceeded;

b. Provide monthly financial reports to the program provider's governing authority and Executive Director as documented in Board minutes;

c. 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;

d. Provide evidence that all generated income accounts are included in required fiscal audits.

III.FM.4. Audited financial statements must be prepared annually by an independent Certified Public Accountant or, for state agency operated programs, the State Auditor's Office. These financial statements:

a. Must include all foundations, component units, and/or related organizations;

b. 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 Administrative to prevent interruptions in grant funding;

c. 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.);

d. Include a management letter describing the financial operation of the program.

III.FM.5. Programs must develop a cost accounting system that defines and determines the cost of single units of service.

III.FM.6. Regional Community Mental Health Centers must prepare and submit to DMH an annual Unit Cost Report using forms and instructions promulgated by DMH. These reports are due within nine (9) months from the end of the agency's fiscal year.

III.FM.7. The program must develop and adhere to purchasing policies and procedures that ensure:

a. 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;

b. 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);

c. The agency maintains adequate documentation to support all purchasing transactions (e.g. requisitions, bids, purchase orders, receiving reports, invoices, canceled checks and contracts);

d. The agency 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.

e. The agency 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;

f. 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;

g. Ensure that all insurance proceeds or proceeds from the sale of grant inventory be returned to the program for which it was initially purchased; and

h. Property and equipment ledgers are periodically reconciled to general ledger accounts.

III.FM.8. The program must develop an accounting system to document grant, match, and funds of individuals receiving services that:

a. 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;

b. 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;

c. 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;

d. 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;

e. 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;

f. 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.

III.FM.9. Bonding is required for all personnel who handle program funds to cover risks associated with employee dishonesty or theft.

III.FM.10. Unless otherwise provided by law, the agency must have insurance that includes liability, fire, theft, disaster, professional liability and workman's compensation.

III.FM.11. All agencies must have policies that include/address the following:

a. Non-discrimination based on ability to pay, race, sex, age, creed, national origin or disability;

b. A sliding fee scale;

c. A method of obtaining a signed statement from the individual receiving services indicating that the individual's personal information provided is accurate;

III.FM.12. 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.

III.FM.13. Accounting records must be maintained on generated income from work contracts that detail dollar amounts and fund utilization as specified in Standard III.FM.3.d.

III.FM.14. The program must maintain evidence of prior written authorization from the DMH/Bureau of Intellectual and 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:

a. Enhancing or enriching the program; and

b. Not being used as part of the required match.

PART IV

SERVICE ORGANIZATION

IV.SO. All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part and subsequent Sections A-K, as they pertain to issues related to general service provision.

SECTION A- GENERAL SECTION

IV.A.1. In addition to complying with the appropriate areas of the current DMH Operational Standards for MH/IDD/SA 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.

IV.A.2. In addition to applicable standards, programs funded by the Mississippi DMH must comply with any additional specifications set forth in individual program grants/contracts.

IV.A.3. Providers must submit all reports and data required by the DMH according to the DMH Manual of Uniform Data Standards.

IV.A.4. All certified providers must comply with official revisions to the DMH Operational Standards for MH/IDD/SA Community Service Providers. Official revisions will be issued by the DMH Executive Director to the Executive Directors of all certified providers for incorporation into policies and procedures as directed by DMH. Official revisions to DMH Standards will include, at a minimum:

a. The applicable DMH Standard numbers that are affected by the official revision.

b. An effective date.

c. The signature of the DMH Executive Director.

IV.A.5. In order to receive an official interpretation of a DMH operational standard, entities must submit a request for official interpretation in writing to DMH. DMH will issue an official interpretation in writing in response to the request.

SECTION B – ELIGIBILITY DETERMINATION

IV.B.1. All of the following information must be documented to support an eligibility determination of serious emotional disturbance:

a. Youth has at least one of the eligible diagnosable mental disorders defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or subsequent editions.

b. Youth with serious emotional disturbance are ages birth up to 21 years.

c. 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.

IV.B.2. All of the following information must be documented to support an eligibility determination of serious mental illness:

a. An individual who meets the criteria for one of the eligible diagnostic categories defined in the most current version of the DSM or subsequent editions.

b. Adults, age 18 and over, with serious mental illness.

c. 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.

SECTION C - ADMISSION TO SERVICES

IV.C.1. Written policies and procedures must address admission to services and must at a minimum:

a. Describe the process for admission or readmission to service(s);

b. Define the criteria for admission or readmission to service(s), including:

(1) Description of the population to be served (age(s), eligibility criteria, any special populations, etc.);

(2) Process for determination of eligibility for service(s) offered by the provider;

(3) Number of residents to be served (providers of community living services only);

(4) Expected results/outcomes; and

(5) Methodology for evaluating expected results/outcomes.

c. Assure equal access to treatment and services for individuals with disabilities who are otherwise eligible;

d. Describe the process or requirements for intake/assessment, including the process for requesting appropriate consent to obtain relevant records from other providers;

e. Describe the procedure for individuals who are ordered to treatment by the court system;

f. Describe written materials provided to individuals upon admission, including materials that may be included in an orientation packet, etc.;

g. Describes the process for informing individuals, youth (if age appropriate) and youth's parent(s)/legal guardian(s) of their rights and responsibilities (including any applicable program rules for residential programs) prior to or at the time of admission;

h. Describe the process to be followed when an individual is found ineligible for admission or readmission to service(s) offered by the provider, including referral to other agencies and follow-up, as appropriate. Such referral(s) and follow-up contacts must be documented;

i. Describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available by the provider; and

j. Assure equal access to treatment and services for HIV-positive persons who are otherwise eligible.

IV.C.2. Providers must have a schedule available to individuals and their families for each service and/or program which includes, at a minimum:

a. Hours of daily operation/hours service and/or program is available;

b. Number of days per year the service and/or program will be provided/is available; and

c. Scheduled dates of closure/unavailability and reasons.

SECTION D - PROGRAM POSTINGS/REQUIRED INFORMATION

IV.D.1. Program rules 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.

IV.D.2. For day and residential programs, emergency telephone numbers must be posted in a conspicuous location near each telephone. Numbers must be included for:

a. Police;

b. Fire;

c. Poison Control Center;

d. Ambulance/Emergency Medical Services (EMS);

IV.D.3. For day and residential programs, the following information should be kept securely at the program/service location:

a. Family member(s) or other contacts (if appropriate and consent is on file) located in a file available to staff; and

b. Case manager and therapist for individuals (if applicable) located in a file available to staff.

SECTION E - SERVICE/PROGRAM DESIGN

IV.E.1. Program activities must be designed to address objectives in Individual Service Plans. Individual Service Plan objectives must reflect individual strengths, needs, and behavioral deficits/excesses 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.

IV.E.2. Services and Programs must be designed to promote and allow independent decision making by the individual and encourage independent living, as appropriate.

IV.E.3. Programs must provide each individual with therapeutic activities and experience in the skills they need to support a successful transition to a more integrated setting, level of service, or level of care.

IV.E.4. The services provided as specified in the Individual Service Plan must be based on the needs and requirements of the individual rather than on the availability of services.

IV.E.5. Prior to discharging someone from a program and/or service because of challenging behavioral issues, the provider must have documentation of development and implementation of a positive behavior support plan. All efforts to keep the individual enrolled in the program and/or service must be documented in the individual's record.

IV.E.6. Providers of outpatient services must describe the range of diagnostic and treatment modalities, as well as family education and support services, to be offered.

IV.E.7. 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:

a. 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.);

b. Includes a written acknowledgment of the school district's receipt and understanding of standards applicable to the children's mental health services.

SECTION F - STAFFING

IV.F.1. 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.

IV.F.2. 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 the licensing entity for which they are licensed.

IV.F.3. If contractual services are provided by a certified provider, or obtained by a certified provider, there must be a current written interagency agreement in place that addresses, at minimum, the following:

a. Roles and responsibilities of both parties identified in the agreement;

b. Procedures for obtaining necessary informed consent, including consent for release and sharing of information; and

c. Assurances that DMH standards will be met by both parties identified in the agreement.

SECTION G- CONFIDENTIALITY

IV.G.1. 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.

IV.G.2. 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. 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:

a. Designated person(s) to distribute records to staff;

b. Specific procedures to assure that records are secure in all locations;

c. 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;

d. 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 continue benefits of the individual. These procedures at a minimum must:

(1) 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;

(2) Describe the process for releasing information about an individual receiving services without prior written consent, that is, in cases of a medical emergency or upon receipt of a court order;

(3) Specify staff authorized to make such release and require that the following is compiled and placed in the record of the individual receiving services:

(a) Individual's name or case number;

(b) Date and time of disclosure;

(c) Information disclosed;
(d) To whom information was disclosed and the reason for disclosure.

(e) The name, credential, and title of the individual disclosing the information.

e. 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;

f. 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;

g. Procedures requiring written consent of the individual receiving services or their guardian, when appropriate, prior to disclosing identifying information to third-party payer;

h. Procedures addressing the release of information regarding individuals receiving alcohol and drug abuse services, in accordance with applicable federal regulations.

IV.G.3. 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.

IV.G.4. All case records must be marked "confidential" or bear a similar cautionary statement.

IV.G.5. The consent to release information form must include:

a. The name of the program which is to make the disclosure;

b. The name or title of the person or organization to which disclosure is to be made;

c. The name of the individual receiving services;

d. The purpose or need for the disclosure;

e. A statement that the consent may be revoked at any time except when action on it has already been taken;

f. The specific condition, event, or date on which the consent will automatically expire, not to exceed twelve months;

g. The extent and nature of information to be disclosed;
h. The date when consent is signed;

i. The signature of the individual receiving services or the signature of a person who is either authorized to give consent or authorized to sign in lieu of the individual;

j. The signature of a witness to the authorization by the individual receiving services to release/obtain information.

IV.G.6. In the case of a community residential program, the program must:

a. Obtain prior written consent from the individual living in the residence or legal representative prior to acknowledging his or her presence in the facility to visitors or to callers;

b. Assure that documentation of such consent is maintained in the case record.

IV.G.7. 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:

a. The purpose of the review;

b. Staff to conduct the review;

c. That reviewer(s) are bound by applicable regulations regarding confidentiality and all others that apply;

d. Reviewer(s) signature(s) and the date signed.

SECTION H- CASE RECORD MANAGEMENT & RECORD KEEPING

IV.H.1. All providers must meet the standards herein and the requirements outlined in the MS DMH Record Guide.

IV.H.2. The program must maintain an indexing or referencing system that allows for locating particular individual case records whenever they are removed from the central file area.

IV.H.3. Records of individuals served by the program must be readily accessible to authorized treatment personnel and there must be written procedures assuring accessibility to records by emergency staff after hours.

IV.H.4. All entries in records of individuals served by the program must be 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. Correction fluid, erasing, or totally marking out original information is not permissible.

IV.H.5. No progress notes in the individual record shall contain the name or other identifiable information of another individual receiving services.

IV.H.6. Individual records must be closed when there has been no contact for a twelve (12) month period. For alcohol and drug services records, the case must be closed when no contacts are recorded for ninety (90) days.

IV.H.7. A record must be maintained for all individuals served by the program and must contain (when applicable) the following information:

a. Face Sheet or Identification Data Form;

b. Intake/Assessment;

c. Comprehensive Individual Service Plan or Service/Activity Plan or Needs Assessment/Aftercare Plan or Plan of Care (for Alzheimer's Day Programs);

d. Case Management Life Domains Assessment/Service Plan;

e. For individuals receiving alcohol and drug abuse services:

(1) Assessment/Educational Activities Documentation Form;

(2). Needs Assessment/Aftercare Plan;

(3) Documentation of detoxification monitoring for primary residential programs;

(4) Documentation of vocational, educational, employment, or related activities for transitional residential program.

f. Documentation of initial staffing and each subsequent staffing/review;

g. Progress Notes and/or Contact Summaries;

h. Medication/Drug Use Profile;

i. Discharge/Termination Summary;

j. Copies of all signed Consent to Treatment, Acknowledgment of Individual's Rights, and Release of Information forms;

k. Any evaluations and diagnostic assessments;

l. Any applicable DMH checklist and certification of eligibility;

m. Consent to release information acknowledging presence of individual served by the program to visitors (if applicable);

n. For individuals who have a legal guardian/conservator appointed by a court of competent jurisdiction, copies of the guardian/conservator order.

o. Copies of any court orders pertaining to outpatient mental health/substance abuse and rehabilitation treatment.

p. For youth served in therapeutic group homes and therapeutic foster care programs:

(1) Documentation that information required in Standard XI.D.1 has been explained/provided in writing to the parent(s), legal guardian(s), and youth prior to or upon admission to the program;

(2) Results of dental examination required in Standard XI.C.5;

(3) Current photograph of the youth;

(4) Educational records and reports;

(5) Copies of any current court order pertaining to the treatment or custody of the youth;

(6) Any permission forms signed by the parent(s)/legal guardian(s) for the youth to participate in specific program activities;

(7) Permission form(s) for staff to provide first aid.

IV.H.8. A licensed physician, with psychiatric training or documented competency in the use of the DSM diagnostic criteria by experience or training, a licensed clinical psychologist, or a psychiatric/mental health nurse practitioner must certify that services are medically/therapeutically necessary as follows for individuals receiving services. (This standard is not applicable for programs for individuals with Alzheimer's Disease/other dementia.)

a. Adults with a serious mental illness (SMI) and children and youth with serious emotional disturbance (SED) must be seen and evaluated by a licensed physician, licensed clinical psychologist, or psychiatric/mental health nurse practitioner as a part of the admission process to certify that the services planned are medically/therapeutically necessary for the treatment of the individual. A licensed physician, licensed clinical

psychologist, or psychiatric/mental health nurse practitioner must then physically visit and evaluate the status of the individual annually thereafter and recertify that the services being provided remain medically/therapeutically necessary.

b. A licensed certified (clinical) social worker may review a client's record for certification by a physician, licensed clinical psychologist or psychiatric/mental health nurse practitioner.

c. Certification and recertification (in a. and b. above) must be documented as part of the Comprehensive Individual Service Plan; and,

d. For individuals receiving Individual Therapeutic Support or Acute Partial Hospitalization, the individual case record must contain a physician's order for the service stating that inpatient care would be necessary without the specific service.

IV.H.9. A functional assessment, approved by the DMH, must be completed for each individual as follows:

a. For individuals admitted to outpatient mental health services for adults, a functional assessment must be conducted between thirty (30) days and sixty (60) days after Intake/Assessment and at least every twelve (12) months thereafter.

b. For individuals admitted to primary alcohol and drug treatment services (which include general outpatient services, DUI treatment services, and primary residential treatment programs), functional assessments and/or other performance measures must be implemented and data submitted as required by the Division of Alcohol and Drug Abuse;

c. For children and youth admitted to mental health services who have 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 guardian 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 Intake/Assessment process and/or of the next occurring Comprehensive Individual Service Plan review.

IV.H.10. Therapeutic activities provided to individuals receiving services must be documented in individualized Progress Notes, which at a minimum:

a. Include the following elements:

(1) A summary of the therapeutic activities of each contact;

(2) An assessment of the progress made toward goals and objectives of the Comprehensive Individual Service Plan, Aftercare Plan and/or Plan for Care for Alzheimer's Day Programs.

(3) A statement of immediate plans for future therapeutic activities.

b. Identify the date, type of service being rendered, and the length of time spent in providing the service.

Alcohol and Drug Services

IV.H.11. The Assessment/Educational Activities Documentation form must be completed for all individuals receiving substance abuse services (except for prevention-only programs) according to the following schedule:

a. All individuals receiving substance abuse treatment services must receive the TB and HIV/AIDS Risks Assessment at the time of the Intake/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 that both risk assessments were administered, with documentation of follow-up of results if applicable, in a primary treatment program completed within the last thirty (30) days.

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

b. All individuals receiving substance abuse treatment services must receive the educational information concerning HIV/AIDS, Sexually Transmitted Diseases, Tuberculosis, and the Mississippi Implied Consent Law as part of treatment either in an individual or group session according to the following schedule:

(1) Prior to completion of treatment for:

(a) Primary Residential Services;

(b) Transitional Residential Services unless the Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that the information was provided during primary treatment;

(c) Chemical Dependency Unit Services;

(d) Intensive Outpatient Services;

(e) Specific DUI Outpatient Treatment Tracks.

(2) Within ninety (90) days of the date of admission for:

(a) General Outpatient Services;

(b) Outreach/Aftercare Services unless the Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that the information was provided during substance abuse treatment.

IV.H.12. In addition to the Intake/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:

(1) Previous DUI's; and,

(2) Moving violations.

b. The results and interpretations of the Mortimer Filkins, SASSI, or other DMH approved diagnostic instrument. The approval must be obtained in writing.

IV.H.13. Providers of detoxification services must maintain documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the detox program and every two (2) hours during the second

twenty-four (24) hours, and as needed thereafter, when prescribed by a physician.

IV.H.14. Providers of Transitional Residential Services must provide in the case records weekly documentation which addresses employment, vocational training, and/or academic activities.

IV.H.15. Providers of Aftercare Services must document in the case record at least one attempted contact per month, unless group, family or individual contact is documented during that month.

SECTION I- TRANSPORTATION OF INDIVIDUALS RECEIVING SERVICES

IV.I.1. 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, and maintenance;

b. When transporting individuals with intellectual/developmental disabilities in one vehicle, there must be one (1) additional staff in addition to the driver for every six (6) individuals.

c. When transporting children age 0-6 years in one vehicle, 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);

d.. When transporting any non-ambulatory person(s) in one vehicle, the staff ratio in addition to the driver must be one (1) staff to six (6) persons being transported;

e. The vehicle must have a securely mounted/fixed fire extinguisher, flares or reflectors, a flashlight, and first aid kit which contains the following: gloves, adhesive bandages, gauze, tape, first aid tape, nonprescription pain relief tablets, sterile pads, antiseptic wipes, oval eye pads, a first aid booklet, and, for programs serving children, non-prescription, non-aspirin liquid pain reliever. Medications must not be expired;

f. All vehicles must have liability insurance unless not authorized by state law; and

g. 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.

IV.I.2. A transport log must be securely maintained in every program vehicle that provides transportation to individuals receiving services. The log must, at a minimum, contain the following information:

a. <u>At time of pick-up</u>:

(1) Vehicle identification (i.e. vehicle number or tag number).

(2) Name of the driver and additional staff (if applicable) on the vehicle.

(3) Names of individuals entering the vehicle.

b. <u>At time of drop-off:</u>

(1) Names of individuals exiting the vehicle

c. Any unusual occurrences during the route should be noted on the transport log.

IV.I.3. Upon arrival to the program site, the driver of the vehicle is responsible for delivering the transport log to program supervisory staff. The vehicle log must be reviewed by supervisory staff to ensure that all individuals receiving services at that program location have exited the vehicle and entered the program site. Upon verification that all individuals have entered the program site, the supervisory staff member must initial the transport log to verify that all individuals being transported have arrived at the program site.

IV.I.4. At the end of the program day, program staff must accompany individuals to their assigned program vehicle for transport. Program staff must supply the driver of the vehicle with a transport log that indicates who is being transported back to their place of residence. Procedures outlined for "time of pick-up" in Standard IV.I.2 should be followed for those individuals being transported to their places of residence. When the individuals arrive at their places of residence, procedures for "drop-off" must be followed.

IV.I.5. Upon completion of the transportation route, the driver of the vehicle and additional staff on the vehicle (if applicable) must review the transport log and verify that all individuals have been returned to their places of residence.

SECTION J- MEDICATION CONTROL

IV.J.1. Programs must have written policies and procedures and documentation of their implementation pertaining to medication control which assures that:

a. The administration of all prescription drugs and/or hazardous 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;

b. All medications must be clearly labeled. Labeling of prescription medications must also include the name of the individual for whom it was prescribed;

c. 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;

d. Adequate space is provided for storage of drugs that is well lighted and kept securely locked;

e. Medication stored in a refrigerator which contains items other than drugs will be kept in a separate locked compartment or container with proper labeling;

f. Drugs for external and internal use will be stored in separate cabinets or on separate shelves which are plainly labeled according to such use;

g. Prescription drugs will be stored in a separate cabinet or compartment from nonprescription drugs.

SECTION K – DISASTER PREPAREDNESS AND RESPONSE

IV.K.1. Providers must develop and maintain an emergency/disaster response plan for each service 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 location/site. For example, the location/site is located near an airport, railroad, nuclear power plant, typical path of tornado, earthquake zone, coastal region, etc. This plan must address at a minimum:

a. Lines of authority and Incident Command

b. Identification of a Local Disaster Coordinator

c. Notification and plan activation

d. Coordination of planning and response activities with local and state emergency management authorities

e. Assurances that staff will be available to respond during an emergency/disaster

f. Communication with individuals receiving services, staff, governing authorities, and accrediting and/or licensing entities

g. Accounting for all persons involved (staff and individuals receiving services)

h. Conditions for evacuation

i. Procedures for evacuation

j. Conditions for agency closure

k. Procedures for agency closure

l. Schedules of drills for the plan

m. 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;

n. The identified or established method of annual fire equipment inspection; and

o. Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.

IV.K.2. 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:

a. Identification of provider's essential functions in the event of emergency/ disaster.

b. Identification of necessary staffing to carry out essential functions

c. Delegations of authority

d. Alternate work sites in the event of location/site closure

e. Identification of vital records and their locations

f. Identification of systems to maintain security of and access to vital records

IV.K.3. Copies of the Emergency/Disaster Response Plans and the Continuity of Operations Plan should be maintained on-site for each location/site and at the agency's administrative offices.

IV.K.4. Emergency/disaster response plans and the continuity of operations plan must be reviewed annually by the governing body. Evidence of this annual review must be documented.

IV.K.5. All locations/sites must document, utilizing the standardized DMH form, implementation of the written plans for emergency/disaster response and continuity of operations. This documentation of implementation must include, but is not limited to the following:

a. Quarterly fire drills for day programs

b. Monthly fire drills for residential programs, conducted on a rotating schedule within the following time frames:

7 a.m. to 3 p.m.
3 p.m. to 11 p.m.
11 p.m. to 7 a.m.;

c. Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.

d. Annual drill of Continuity of Operations Plan for the agency.

IV.K.6. Any revisions to the emergency/disaster response plans and the continuity of operations plan should be documented and approved by the agency's governing body. Any revisions should be communicated in writing to all staff.

IV.K.7. All community residential programs should maintain emergency/disaster preparedness supplies to support individuals receiving services and staff for a minimum of seventy two (72) hours post event. At a minimum, these supplies should include the following:

a. Non-perishable foods

b. Manual can opener

c. Water

d. Flashlights and batteries

e. Plastic sheeting and duct tape

f. Battery powered radio

g. Prescription and nonprescription medications based on needs of individuals in the program and guidance of agency medical staff

h. Personal hygiene items

PART V

RIGHTS OF INDIVIDUALS RECEIVING SERVICES

All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part and subsequent Sections A-F.

SECTION A- RIGHTS

V.A.1. There must be written policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal guardian(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. The individual receiving services and/or parent/legal guardian must also be given a written copy of these rights, which at a minimum, must include:

a. The options within the program and of other services available;

b. Program rules and regulations;

c. Program's responsibility for the referral of those persons whom the program is unequipped to serve;

d. The right to refuse treatment;

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

(1) The right not to be subjected to corporal punishment;

(2) The right to be free from all forms of abuse or harassment;

(3) The right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

(4) The right to considerate, respectful treatment from all employees and volunteers of the provider program.

f. The right to voice opinions, recommendations, and to file a written grievance which will result in program review and response without retribution. (See also Part II, Organization and Management, Standard II.A.5. and Part V, Rights of Individuals Receiving Services, Section F.);

g. The right to personal privacy, including privacy with respect to facility visitors in day programs and residential programs as much as physically possible;

h. The program's nondiscrimination policies related to HIV infection and AIDS;

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

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

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

l. The right to participate in and receive a copy of the Individual Service Plan including but not limited to the following:

(1) The right to make informed decisions regarding his/her care, including being informed of his/her health status, being involved in care planning and treatment and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(2) The right to access information contained in his/her clinical records 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 medical records and must actively seek to meet these requests as quickly as its record keeping system permits. State statute 41-21-102 (7) does allow for restriction to access to records in certain circumstances where it is medically contraindicated; and,

(3) The right to be informed of any hazardous side effects of medication prescribed by staff medical personnel.

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

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

o. The right to receive care in a safe setting.

V.A.2. Providers must establish and implement written policies and procedures specifying that:

a. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support.

b. Providers are prohibited from the use of seclusion except for certified Crisis Stabilization Units (See Standard XI.J.34 through XI.J.36).

c. Providers are prohibited from the use of chemical restraints.

The definitions of seclusion, mechanical restraint and chemical restraint are as follows:

(1) Seclusion means a behavior control technique involving locked isolation. Such term does not include a time-out.

(2) 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.

(3) 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.

V.A.3. Providers must ensure that all staff who may utilize physical restraint(s)/escort successfully complete training and hold a nationally recognized or DMH-Approved Program for managing aggressive or risk-to-self behavior.

V.A.4. Providers must maintain a listing of all supervisory or senior staff members who have successfully completed required training and demonstrate competency in utilization in physical restraint(s).

V.A.5. Providers utilizing physical restraint(s)/escort must establish and implement written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum;

a. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use;

(1) 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.

(2) 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.

b. 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. 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, staff, or others (see **V.A.6** for need of Behavior Support Plan);

c. Requirements that physical restraints/escorts are used as specified in the Behavior Support 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;

d. Requirements that physical restraint(s)/escort are being used in accordance with a Behavior Support 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.

V.A.6. 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 and in each individual case record:

a. 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);

b. 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 day period with the same individual. The Behavior Support Plan must address the behaviors warranting the continued utilization of physical restraint(s)/escort procedure in emergency situations. The Behavior Support Plan must be developed with the signature of the program's clinical director.

c. In physical restraint situations, the treating physician must be consulted within twenty-four hours and this consultation must be documented in the individual's case record.

d. 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 hour of initiation of the intervention. Procedures must also ensure that the supervisory or senior staff person trained as per Standard V.A.3 monitors the situation for the duration of the intervention;

e. Requirements that staff record 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. The log must include:

(1) Name of the individual for whom the physical restraint(s)/escort intervention is implemented;

(2) Time that physical restraint(s)/escort intervention began;

(3) Behavior warranting utilization of physical restraint(s)/escort intervention;

(4) Type of physical restraint(s)/escort that was utilized during intervention.

(5) Documentation of less restrictive alternative methods of managing behavior which have been determined to be ineffective in the management of the individual's behavior.

(6) Documentation of visual observation by staff of individual while he/she is in physical restraint(s)/escort, including description of behavior at that time;

(7) Time that the physical restraint(s)/escort intervention ended;

(8) Signature of staff implementing physical restraint(s)/escort procedure and staff observing individual for whom physical restraint(s)/escort intervention was implemented.

(9) Documentation of supervisory or senior staff person's assessment of the restrained/escorted individual's mental and physical well-being

during and after physical restraint(s)/escort utilization, including the time the assessment was conducted.

(10) Documentation of the use of physical restraint(s)/escort in emergency situations must clearly describe the precipitating events that necessitated their use.

V.A.7. 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) minutes at any one time. They must be released after those sixty minutes. A face-to-face assessment must take place at least every twenty (20) minutes while the individual is being restrained.

V.A.8. 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 treatment/service/Individual Service Plan of the individual being served as well as <u>all</u> of the following:

a. Requirement(s) that physical restraint(s)/escort must be implemented in the least restrictive manner possible;
b. Requirement(s) that physical restraint(s)/escort must be in accordance with safe, appropriate restraining techniques; and;

c. 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 in no longer in danger of harming him/herself or others ;)

d. Requirement(s) that physical restraint(s)/escort must not be used as a form of punishment, coercion or staff convenience;

e. Requirement(s) that supine and prone restraints are prohibited as part of an individual's Behavioral Support Program; and

f. Requirement(s) that all physical restraint(s)/escort can only be implemented by someone holding certification as per Standard V.A.3.

V.A.9. 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 policy/procedures must include, at a minimum, the following provisions:

a. Clear definition(s) of time-out and the appropriate conditions and documentation associated with its use:

(1) 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.

(2) 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.

b. Requirement(s) ensuring that the use of time-out procedures is justified as documented and approved in an Individual Service Plan;

c. Requirement(s) ensuring that time-out be 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; and

d. Requirement(s) that a locked door must not be component of timeout.

V.A.10. 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 can not exceed one (1) hour.

V.A.11. There must be written and implemented policies and procedures requiring that a Behavior Support Plan be developed by the individual's treatment 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:

a. The Behavior Support Plan must be developed in accordance with the individual's comprehensive treatment/Individual Service Plan and have signature approval by the program's clinical director.

b. The Behavior Support Plan must not include the use of time-out as a form of punishment, coercion or for staff convenience.

V.A.12. The utilization of time-out must be documented in a behavior log completed/maintained in the individual's case record which, at a minimum, must include:

a. Name of the individual for whom the time-out intervention is implemented;

b. Time that time-out intervention began;

c. Behavior(s) requiring time-out intervention;

d. Documentation of visual observation by staff while individual is in time-out, including description of behavior at that time;

e. Time that the intervention ended; and

f. Signature of staff implementing procedure and observing individual for whom time-out intervention was implemented.

V.A.13. In the case of residential placement, the program must have written and implemented policies and procedures that:

a. Provide the individual receiving services with means of communicating with persons outside the program;

b. Provide for visitation by close relatives and/or significant others during reasonable hours;

c. Provide for safe storage, accessibility and accountability of funds of individuals receiving services;

d. Provide for individuals to send/receive mail without hindrance;

e. Provide for individuals to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in the individual case record. (Any individual restriction on private telephone use must be reviewed at a minimum every seven days).

V.A.14. 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 or the program must have a policy that the individuals do not work for the program.

V.A.15. A record of any individuals for whom the provider is a conservator or a representative payee must be on file with supporting documentation.

V.A.16. For programs serving as conservator or representative payee, the following action must be taken for each individual:

a. 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;

b. The individual and/or his/her lawful agent 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.

V.A.17. All programs that provide services for children under the age of eighteen (18) must have on file an assurance signed by the Executive Officer of the provider stating compliance with provisions of Public Law 103-227 (Pro-Children Act of 1994). Note: This standard includes a current Certification Regarding Environmental Tobacco Smoke required of providers funded by the DMH.

V.A.18. In all Alcohol and Drug Abuse Residential programs, smoking is prohibited within ten (10) feet of the main entrance.

SECTION B- STAFF ROLES IN PROTECTING RIGHTS OF INDIVIDUALS

V.B.1. The program 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 guardians/legal representative.

V.B.2. The program's policies and procedures must be written in such a way that staff member's roles in maintaining or explaining these rights is clearly defined.

V.B.3. The policies and procedures must also clearly explain how the program will train staff members with 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 guardian/legal representative. Training should focus on the population to be served, but can include other related areas for broadened understanding. Training should include, but is not limited to:

a. The effects of stigma,

b. Developing empathy, and

c. The roles of family members and caregivers in treatment and services.

SECTION C- ETHICAL CONDUCT

V.C.1. In addition to complying with ethical standards set forth by any relevant licensing or professional organizations, 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. Examples of breeches of ethical or moral conduct toward individuals, their families, or other vulnerable persons, include but are not limited to, the following:

a. Borrowing money or property;

b. Accepting gifts of monetary value;

c. Sexual (or other inappropriate) contact;

d. Entering into business transactions or arrangements;

e. Physical, mental or emotional abuse;

f. 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;

g. Exploitation;

h. Failure to maintain proper professional and emotional boundaries;

i. Aiding, encouraging or inciting the performance of illegal or immoral acts;

j. Making reasonable treatment-related needs of the individual secondary or subservient to the needs of the employee or volunteer;

k. Failure to report knowledge of unethical or immoral conduct or giving false statements during inquiries to such conduct; and,

l. Action or inaction, which indicates a clear failure to act in an ethical, moral, legal, and professional manner.

SECTION D- CULTURAL COMPETENCY/ LIMITED ENGLISH PROFICIENCY SERVICES

V.D.1. Language assistance services, including bilingual staff and interpreter services, must be offered at no cost to individuals receiving services with limited English proficiency at all points of contact.

V.D.2. Language assistance services must be offered in a timely manner during all hours of operation.

V.D.3. 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.

V.D.4. Service providers must assure the competence of the language assistance provided.

V.D.5. Family and/or friends of the individual receiving services should only be utilized to provide interpreter services when requested by the individual receiving services.

V.D.6. Service providers must make available easily understood consumer related materials and post signage in the language of groups commonly represented in the service area.

SECTION E- SERIOUS INCIDENT REPORTS AND RECORDS

V.E.1. All serious incidents involving an individual receiving services or a staff member on program property or at a program-sponsored event must be reported to the DMH, Office of Constituency Services, the agency director, parent(s)/guardian(s) or other significant persons as identified by the individual receiving service and documentation of such incident report maintained in a central file on site.

V.E.2. A written policy for documenting and reporting all serious incidents must be in place locally. Documentation regarding serious incidents must include a written description of events and actions, written reports and telephone calls to the DMH, Office of Constituency Services.

V.E.3. Serious incidents (such as those described in Standard V.E.4.) must be reported to the DMH, Office of Constituency Services as soon as possible, but no later than twenty-four (24) hours, in one of the following ways:

a. The Serious Incident Report Form documenting a description of the incident, action and resolution must be submitted to the DMH, Office of Constituency Services as soon as possible, but no later than within twenty-four (24) hours or;

b. A report must be made to the DMH, Office of Constituency Services by telephone as soon as possible, but no later than within twenty-four (24) hours or the next working day, followed by a completed written Serious Incident Report Form documenting a description of the incident, action and resolution. The Serious Incident Report form must be received by the DMH within five working days of the incident.

V.E.4. The following are examples of types of serious incidents that must be reported to the DMH, Office of Constituency Services and other appropriate authorities within twenty-four (24) hours or the next working day, as specified below:

a. Suicide attempts on program property or at a program-sponsored event.

b. Unexplained absence from a residential program of twenty-four (24) hour duration.

c. Absence of an individual receiving services of any length of time from an adult day center providing services to persons with Alzheimer's disease and/or other dementia (i.e., wandering away from the premises) must be reported to the DMH, Office of Constituency Services within 24 hours of its occurrence.

e. Emergency hospitalization or emergency room treatment of an individual while in the program.

f. Accidents which require hospitalization, may be related to abuse or neglect, or in which the cause is unknown or unusual.

g. Disasters, such as fires, floods, tornadoes, hurricanes**,** blizzards, etc.

h. Any type of mandatory evacuation by local authorities that affects the program/facility or site,

i. Use of seclusion or restraint.

V.E.5. Death of an individual on program property, participating in a program-sponsored event, being served through a certified residential program, or during an unexplained absence of the individual from a residential program site must be reported verbally to the Office of Constituency Services within eight (8) hours to be followed by the required serious incident form within twenty-four (24) hours.

NOTE: This list is not intended to be exhaustive. Programs should use discretion. If there is doubt, contact the DMH, Office of Constituency Services.

SECTION F- GRIEVANCE AND COMPLAINT RESOLUTION

V.F.1. There must be written policies and procedures for implementation of a process through which individuals' complaints and grievances can be reported and addressed at the local program/center level. These policies and procedures, minimally, must ensure the following:

a. That individuals receiving services from the provider have access to a fair and impartial process for reporting and resolving grievances and complaint;

b. That individuals are informed and provided a copy of the local procedure for filing a grievance/complaint with the provider and of the procedure and timelines for resolution of complaints and grievances

c. That individuals receiving services and/or parent(s)/legal guardian(s) are informed of the procedures for reporting/filing a complaint/grievance with the DMH, including the availability of the toll free telephone number.

d. That the program will post in a prominent public area the OCS poster containing information for filing a grievance or complaint with DMH. A poster is required at each site/service location.

V.F.2. The policies and procedures for resolution of complaints and grievances at the program/center level, minimally, must include:

a. Definition of complaints and grievances

(1) Complaints: verbal statement made by an individual receiving services alleging a violation of rights or policy

(2) Grievances: a written statement made by an individual receiving services alleging a violation of rights or policy

b. Statement that complaints and grievances can be expressed without retribution;

c. The opportunity to appeal to the executive officer of the program, as well as the governing board of the program;

d. Timelines for resolution of complaints/grievances;

e. The toll-free number for filing a grievance/complaint with the DMH.

V.F.3. 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 program/center

V.F.4. The policies and procedures must also include a statement of compliance with timeline issued by DMH Office of Constituency Services in resolving complaints originating at the DMH.

PART VI

HUMAN RESOURCES

All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part and subsequent Sections A-D.

SECTION A- PERSONNEL POLICIES

VI.A.1. The program must have written personnel policies and procedures that at a minimum:

a. 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;

b. Prohibit pre-employment inquiries about the nature of an applicant's disability which does not affect their ability to perform the job.

VI.A.2. The written personnel policies must describe personnel procedures addressing the following areas:

a. Wage and salary administration;

b. Employee benefits;

c. Working hours;

d. Vacation and sick leave (includes maternity leave);

e. Annual job performance evaluations. Job performance evaluations must be in writing, and there must be documented evidence that evaluations are reviewed with the employee;

f. Suspension or dismissal of an employee, including the employee appeal process;

g. Private practice by program employees.

VI.A.3. Staff must be designated, with documentation in their respective job description(s), to implement and/or coordinate personnel policies and procedures and to:

a. Maintain personnel records;

b. Disseminate employment information to program staff;

c. Supervise the processing of employment forms.

VI.A.4. There must be documentation of staff members' initial review of the program's Policies and Procedures Manual within thirty (30) days of hire, along with documentation of staff members' review of any subsequent changes.

SECTION B- PERSONNEL RECORDS

VI.B.1. 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 current Mississippi license or certification for all licensed or certified personnel;

c. A copy of college transcripts, high school diploma, and/or appropriate documents to verify that educational requirements of the job description are met;

d. Wage and salary information, including all changes;

e. A copy of the annual performance evaluation;

f. Documentation of contact with at least two of the listed references, one of which must be a former employer and/or professional reference;

g. A written job description along with documentation of annual review by employee and supervisor, including necessary updates as appropriate. The job description shall include, at a minimum:

(1) Job title;

(2) Responsibilities of the job;

(3) Skills, knowledge, training/education and experience required for the job.

h. A copy of a valid driver's license for all designated drivers;

i. 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 Executive Director of the organization.

j. 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 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.

SECTION C- QUALIFICATIONS

VI.C.1. Unless otherwise specified herein, all staff employed on and after the effective date of these standards must meet the minimum qualifications listed below. In order for a service provider to receive funds and/or certification for services provided from the DMH or other approved sources, the provider must maintain documentation that:

a. Director(s) with overall responsibility for a service or service area(s) (such as Community Services Director, Director of Case Management Services, Director of HCBS Waiver Support Coordination, Program Director for Adult and Children's Partial Hospitalization, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, Mental Illness Management Services (MIMS)) must have at least a Master's degree in mental health or intellectual/developmental disabilities, or a related field and (1) a professional license or who (2) is a DMH credentialed Mental Health Therapist or DMH credentialed Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served and/or supervised).

b. In addition to the requirements outlined in Standard VI.C.1.a., Directors of Therapeutic 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.

c. Supervisor(s) with predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services for such areas as Work Activity, Community Living (with the exception of Therapeutic Foster Care and Therapeutic Group Homes), Day Habilitation, Clubhouse Programs, etc., must have at least a Bachelor's degree in a Mental Health, Intellectual, 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.

d. Psychiatric services, including such services as 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) 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;

(3) A psychiatric/mental health nurse practitioner licensed by the Mississippi Board of Nursing.

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

e. 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 Law and Rules and Regulations. Nursing services are physician prescribed nursing services necessary for the support and habilitation/rehabilitation of the recipient;

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

g. Psycho-educational evaluation services are provided by a psychometrist certified by the Mississippi Department of Education;

h. Therapy or Counseling services are provided by an individual with at least a Master's degree and (1) a professional license (i.e. LMSW, LPC, LMFT) or who (2) is a DMH Certified Mental Health Therapist or DMH

Certified Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served).

i. In addition to the requirements outlined in Standard VI.C.1.h, the mental health therapist in Therapeutic 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.

j. All Day Treatment Specialists providing direct 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 (i.e. LMSW, LPC, LMFT) or (2) hold DMH credential as a Mental Health Therapist or a Intellectual/Developmental Disabilities Therapist, as appropriate to the population served.

k. Case management services, other than School Based or MIMS, 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 DMH Case Management Credential. ID/DD Waiver Support Coordination can also be provided by a Registered Nurse;

l. School Based Services (Case Management Services) and MIMS are provided by an individual with at least a Master's degree and (1) a professional license (i.e. LMSW, LPC, LMFT) or who (2) is a DMH Credentialed Mental Health Therapist or DMH Certified Intellectual/Developmental Disabilities Therapist, as appropriate to the population being served.

m. 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.

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

o. All staff providing Peer Support Services (i.e. Peer Specialist) must possess a high school degree or GED equivalent, self identify as a current or former consumer of mental health services, demonstrate a minimum of 12 months in self-directed recovery in the last year, and

successfully complete the DMH approved Certified Peer Specialist training and certification exam.

p. Support staff such as Aide, House Parent, House Manager, Secretary, Office Clerk, Bookkeeper, Cook, Direct Care Worker, Direct Support Professionals, Work Trainer, Production Assistant, staff providing Individual Therapeutic Support Services, Day Treatment Assistants, support staff in Psychosocial Rehabilitation (clubhouse), Elderly Psychosocial Rehabilitation, and Day Support Programs, Day Habilitation worker, home and community support services staff, job coaches, etc., must have at least a high school education or a GED and be at least twenty-one (21) years old. Staff providing Individual Therapeutic Support Services must also complete certification approved by the DMH.

VI.C.2. The following standards are only applicable to providers certified under the DMH/H option.

a. Behavioral Support Interventionist(s) who conduct evaluations and develop behavior support plans must:

(1) hold a current license to practice medicine or psychology, verifiable by their respective state licensing entities; or,

(2) be a currently Licensed Certified Social Worker; or,

(3) have a degree in a related field such as special education or psychology;

(4) and have four (4) years of documented experience developing and implementing behavior support/intervention programs for individuals with IDD.

b. Staff who provide/implement direct behavior support/intervention services must:

(1) hold a current license to practice medicine or psychology, verifiable by their respective state licensing entities; or,

(2) be a currently licensed clinical social worker; or,

(3) have a degree in a related field such as special education or psychology;

(4) and have two (2) years of documented experience developing and implementing behavior support/intervention programs for individuals with IDD.

VI.C.3. Unless otherwise specified herein, all staff employed on and after the effective date of these standards must meet the minimum qualifications listed below for providers of Substance Abuse Prevention and Rehabilitation Services.

a. Directors of Alcohol and Drug residential programs for adults must have at least a:

(1) Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field and two (2) years of experience in the field of substance addiction/abuse treatment/prevention. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs or;

(2) Bachelor's degree in mental health or intellectual/developmental disabilities or a related behavioral health field and two (2) years of experience in the field of substance addiction/abuse treatment/prevention. They must also complete an alcohol/drug treatment certification program approved by DMH within 30 months of the date of employment. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs.

b. Directors of Inpatient Chemical Dependency Unit, and Adolescent Residential Treatment Programs, must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field, and at least two (2) years of experience in treatment/prevention of substance addiction/ abuse. If the person is recovering from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs is required.

c. Support staff employed in Alcohol and Drug Abuse Residential Programs who are in recovery must also have a minimum of one (1) year of non-abusive use of alcohol and/or drugs.

d. Alcohol and Drug Abuse Prevention Specialists must have at least a Bachelor's degree. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs is required.

e. Alcohol and Drug Abuse Coordinators 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. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs is required.

f. Alcohol and Drug Abuse Outpatient Therapists/Counselors, must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field. Intensive Outpatient Programs must consist of a director who meets the requirements listed above and at least one back-up or support staff member. All back-up/support IOP staff must have at least a Bachelor's degree in one of the same educational fields mentioned above. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs is required. *(See also j. that follows.)*

g. Directors of Intensive Outpatient Programs (IOP) must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs.

h. All back up/support IOP Staff must have at least a Bachelor's degree in mental health or intellectual/developmental disabilities or a related behavioral health field. For individuals who are in recovery from chemical

dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs.

i. Alcohol and Drug Abuse Chemical Dependency Unit and Residential Program counseling staff and all aftercare workers must have at least a high school diploma or equivalency. These individuals must also successfully complete an alcohol and drug treatment certification program approved by DMH within thirty (30) months of the date of employment. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs is required. *(See also j. that follows.)*

j. Providers certified as DMH/C that provide the following 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 hold (1) a professional license (2) a DMH Mental Health Therapist credential. (This requirement also applies to counseling services provided in alcohol/drug residential treatment programs operated by DMH/C providers and billed to Medicaid.)

VI.C.4. Unless otherwise specified herein, all staff employed on and after the effective date of these standards must meet the minimum qualifications listed below for providers of Programs of Assertive Community Treatment (PACT) for adult mental health services.

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 works on a full-time or part-time basis (as required in Standard XIII.A.6) 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 Specialist: A mental health professional with training and experience in substance abuse 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 specialist. Peer 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 degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services 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 education or a GED and be at least twenty-one (21) years old.

VI.C.5. Community Mental Health Center providers (certified under the DMH/C option) 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 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;

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.

VI.C.6. Community Mental Health Center providers (certified under the DMH/C option) must employ 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, i.e., with administrative authority and responsibility for children's mental health services.

VI.C.7. Unless otherwise specified herein, all individuals employed on and after the effective date of these standards must meet the 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 twelve (12) months in self-directed recovery.

d. Individuals must provide documentation of successful completion of at least one of the DMH recognized peer programs.

e. Individuals must be a DMH certified Peer/Family Support Specialist under the supervision of a mental health professional.

VI.C.8. If a provider uses volunteers, there must be policies and procedures describing, at a minimum, the following:

a. The scope and objectives of the volunteer service (role and activities of volunteers);

b. Supervision of volunteers by staff member in areas to which volunteers are assigned;

c. Process for recruitment, assignment, and evaluation of volunteers; and,

f. Implementation of an orientation training program (See also Section D below).

SECTION D- TRAINING/STAFF DEVELOPMENT

VI.D.1. All new employees and volunteers/interns must attend General Orientation. General orientation must be provided within 30 days of hire/placement, except for direct
service providers and direct service interns/volunteers who must receive training prior to contact with individual receiving services.

VI.D.2. General Orientation must consist of a minimum of four (4) hours. At a minimum, General Orientation must address the following areas:

a. Overview of the agency's mission and an overview of the agency policies and procedures

b. Health and Safety

(1) Basic First Aid
(a) Choking
(b) Seizures

(2) Infection Control
(a) Universal Precautions
(b) Hand-washing

(3) Workplace Safety
(a) Fire and Disaster Training
(b) Emergency/Disaster Response
(c) Incident reporting
(d) Reporting of suspected abuse/neglect

c. Rights of Individuals Receiving Services

d. Confidentiality

e. Family and Cultural Issues

(1) Respecting Cultural Differences

f. Basic standards of ethical and professional conduct

(1) Drug Free Workplace
(2) Sexual Harassment
(3) 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 o**nly***

VI.D.3 Providers must develop an Annual Initial Staff Training Plan specific to each position classification as listed below. Each Initial Staff Training Plan should be based on job responsibilities, program/position requirements, and identified staff needs. The Initial Staff Training Plan should be reviewed annually for changes and/or updates and should be available for review. Position specific training must be provided within 90 days of hire and consist of a minimum of 20 hours of training (medical personnel excluded).

a. The following position classifications must be addressed:

(1) Direct service provider (i.e., therapist, case manager, program assistants)
(2) Administrative/support staff (i.e., office manager, medical records technician, housekeeper, accounting staff)
(3) Interns/Volunteers

VI.D.4. 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 should be reviewed annually for changes and/or updates and should be available for review.

a. The following position classifications and required minimum hours of continuing education must be addressed:

(1) Direct service provider (i.e., therapist, case manager, program assistants). A minimum of thirty (30) continuing education hours every two (2) years must be completed by all individuals in this position class.

(2) Administrative/support staff (i.e., office manager, medical records technician, housekeeper, accounting staff). A minimum of sixteen (16) continuing education hours every two (2) years must be completed by all individuals in this position class.

(3) Medical personnel (i.e., psychiatrist, nurses) – as required by state licensing boards.

Note: Continued licensure/certification relative to an employee's job position may be substituted for the continuing education requirement.

VI.D.5. At a minimum, Initial Staff Training Plans and Continuing Education Plans must address the following areas:

a. Crisis prevention and intervention

b. Abuse reporting

c. Record Keeping

d. DMH Standards relative to expectations of specific program

VI.D.6. All staff is required to participate in orientations, program/position specific training, staff development opportunities, and other meetings as required by their position specification.

VI.D.7. Documentation of training that individual staff has received must be included in individual and/or personnel records. This documentation must include:

a. Name of training

b. Name of person(s) participating in the training

c. Instructor's name and credentials

d. Date of training

e. Length of time spent in training

f. Topics covered

g. Learning objectives

PART VII

ENVIRONMENT/SAFETY

All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part.

VII.ES.1 All facilities must meet state and local fire, health, and safety codes with documentation maintained on site, as follows:

a. Facilities 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 of fire and health inspections.

b. Documentation by appropriate fire and health authorities that noted citations have been corrected must be maintained on-site.

c. Facilities with an existing sprinkler system must have annual inspection by a licensed company or the local fire authorities.

d. Facilities must provide evidence and documentation of a systematic pest control program. This documentation must be maintained on site.

e. The identified or established method of annual fire equipment inspection;

f. Evidence that fire extinguishers are being recharged or replaced after 6 years;

g. Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.

VII.ES.2. Each facility must have at a minimum the following:

a. Operable fire extinguishing equipment and alarms/detectors located throughout the facility in all areas where conditions warrant (i.e. flammable storage areas, kitchens) and must be mounted in a secure manner;

b. Operable carbon monoxide detectors located in any facility 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 1,000 square foot area or less.

VII.ES.3. Escape routes must be posted in highly visible locations throughout the environment, clearly indicating where a person is located in relation to the nearest exit(s).

VII.ES.4. 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.

VII.ES.5. The interior and exterior of each facility and program must be maintained in a safe and sanitary manner. This must include, but not be limited to, the following:

a. The water temperature in all hot water fixtures used by individuals enrolled in DMH programs must be maintained between 100 and 120 degrees Fahrenheit. Hot Water Heaters must be on a documented inspection schedule;

b. Emergency lighting systems 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 must be tested for a continuous length of at least 30 seconds per month and one continuous 4 hour test per year. Provider must maintain documentation of testing.

c. 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:

(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.

d. The facility including furnishings and/or the physical environment must be clean, well-kept and in good repair;

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

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

VII.ES.6. Facilities 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).

VII.ES.7 The clear width of doorways when the door is in the full open position must not be fewer than thirty-two (32) inches.

VII.ES.8 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.

VII.ES.9. Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met:

a. 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.

b. The locking device is one that is readily distinguishable as locked.

c. A key is immediately available to any staff inside the building when it is locked.

d. There may only be one locked door per means of egress.

VII.ES.10. At least one restroom must be accessible to individuals with physical disabilities with either one accessible restroom for each sex or one accessible unisex restroom being acceptable. Additionally, non-residential programs

serving individuals with ID/DD must have adequate private changing facilities.

VII.ES.11. The accessible restroom stall must have grab bars behind the toilet and on the side wall nearest to the toilet and on the side wall nearest the lavatory/sink.

VII.ES.12. 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.

VII.ES.13. All doors, including stall doors in the restroom, must be operable with a closed fist from inside the exit.

VII.ES.14. Restroom door locks must be designed to permit the opening of the locked door from the outside.

VII.ES.15. Doors opening onto stairs must have a landing, at a minimum, the width of the door.

VII.ES.16. Minimum head room on stairs to clear all obstructions must be six feet and eight inches (6' 8").

VII.ES.17. Stairs in the program facility(ies) must have the following dimensions:

a. Stair width must be at least thirty-two (32) inches;

b. Minimum tread depth of each step of the stairs must be at least nine (9) inches;

c. Maximum height of risers in each step must not exceed eight (8) inches;

VII.ES.18. 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.

a. Guards and handrails must continue for the full length of the ramp or stairs;

b. Handrails must provide at least one and one-half (1.5) inches between the inner side of the rail and support wall;

c. Handrails must be located between thirty (30) inches to thirty-four (34) inches above the tread of the step or ramp.

VII.ES.19. Steps, ramps and platforms and landing(s) associated with them must be:

a. Designed for at least one hundred (100) pounds per square foot;

b. Have a slip-resistant surface.

VII.ES.20. 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.

VII.ES.21. No portable heaters are allowed in service areas.

VII.ES.22. Two (2) means of exit per living/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.

VII.ES.23. 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 apartments/supported living). The signs must be lighted at all times. In the case of electrical failure the illuminated lights should be battery operated in order to be readily visible.

VII.ES.24. 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.

VII.ES.25. Any program that has drinking fountains must have at least one fountain that meets the following specifications:

a. Has clear floor space of at least 30 by 48 inches in front;

b. Has a spout no higher than 36 inches from the floor;

c. Has controls mounted on front or side near the front edge and be operable with a closed fist.

VII.ES.26. Each program must have a first aid kit. The kit must contain gloves, adhesive bandages, gauze, tape, first aid tape, nonprescription pain relief tablets, sterile pads, antiseptic wipes, oval eye pads, a first aid booklet, and, for programs serving children, non-prescription, non-aspirin liquid pain reliever. 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.

VII.ES.27. All facilities must have operational utilities (light, water/sewer, heat, electricity). Facilities must also have a plan in place in case utilities fail.

PART VIII

EMERGENCY/CRISIS SERVICES

VIII.ECS. Emergency/Crisis Services are those designated for immediate intervention(s) available to individuals experiencing personal crisis. Emergency/Crisis Services are included in the minimum required services that must be provided by entities certified as DMH/C. Emergency/Crisis Services must be made available by providers designated as DMH/C to the following populations: adults, children, youth, and individuals with intellectual/developmental disabilities.

SECTION A – EMERGENCY/CRISIS SERVICES

VIII.A.1. Emergency/Crisis Services are time-limited interventions, available twenty-four (24) hours a day, seven (7) days per week. When needed, trained emergency/crisis response staff triage referrals and respond in a timely and adequate manner to diffuse the current personal crisis situation. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation. Program staff must be able to triage and make appropriate clinical decisions, including accessing the need for inpatient services or less restrictive alternatives.

VIII.A.2. Expected outcomes of emergency/crisis services include:

a. Individuals have access to face to face contact 24/7 (see VIII.A.5. below).
b. Providers certified as DMH/C must have documented formal agreements (or denial of agreements) with every emergency room in the CMHC catchment area.
c. Training regarding the handling of mental health related emergencies/ crises is provided to identified emergency personnel.
d. Individuals are provided alternatives to hospitalization.
e. Individuals' reliance on inpatient hospitalization will decrease.

VIII.A.3. Emergency/Crisis Services must be made available in every county/area served by the provider.

VIII.A.4. Recipients of Emergency/Crisis Services are not required to be already established consumers of services provided by the community mental health center.

VIII.A.5. The provider must ensure that a mental health representative is available to speak with an individual in crisis and/or family members/legal guardians of the individual twenty-four (24) hours a day, seven (7) days a week. An accessible toll free number must be made available for this purpose. Individuals in crisis should only have to dial one number for assistance. Answering services are permissible as long as the individual speaks with a trained professional. Answering machines are not permissible.

VIII.A.6. 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. This individual is not required to see the individual in their home (however this is permissible), but there must be designated, strategic, publicized locations that the person can be seen. The individual must be seen within one (1) hour of initial time of contact for those in urban settings and within two (2) hours of initial time of contact for those in rural settings.

VIII.A.7. Appointments for individuals in crisis that can be resolved over the telephone must be provided the next day, twenty-four (24) hours a day, seven (7) days a week.

VIII.A.8. Assessment and treatment to individuals held in jail waiting inpatient commitment must be provided twenty-four (24) hours a day, seven (7) days a week.

VIII.A.9. All persons involved in the provision of emergency services must be provided training in the handling of mental health emergencies and crisis intervention.

VIII.A.10. There must be documentation that all staff assigned to emergency/crisis services are trained in the policies and procedures required for pre-evaluation screening and civil commitment.

VIII.A.11. The provider must annually have current written interagency agreement(s) or contract(s) with licensed hospitals to provide emergency room services that at a minimum address the following:

a. Training of emergency room staff in handling mental health emergencies;

b. Availability of hospital emergency room services to address the needs of individuals in crisis;

c. Availability of face-to-face contact with a mental health professional; and

d. 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.

VIII.A.12. If a DMH-certified Crisis Stabilization Unit is available in the area, the provider must annually have current written interagency agreement(s) or contract(s) with the Crisis Stabilization Unit for assessment twenty-four (24) hours a day, seven (7) days a week.

VIII.A.13. Emergency/Crisis service availability must be publicized, including a listing in the telephone directories for the area served by the program.

VIII.A.14. Providers of emergency/crisis services must maintain a written, daily log of emergency/crisis face-to-face and telephone contacts, including, at a minimum:

a. Identification of individuals involved in the emergency/crisis;

b. Time and date contact to the provider was initiated by the individual and/or family member/legal guardian.

c. Time and date that emergency face-to-face contact and/or telephone contact;

d. If face-to-face contact was made, identification of location of contact;

e. Presenting problem(s);

f. Action(s) taken by emergency services staff;

g. Documentation of notification and involvement of significant others, and when contact is deemed inappropriate, indication of why notification was not made.

h. Disposition or resolution of the emergency/crisis, including:

(1) Condition of the individual(s) at the last face-to-face contact and/or termination of the telephone call; and,

(2) Services to which the individual and/or family was referred.

i. Name and position of staff member(s) addressing the emergency/crisis.

SECTION B – INTENSIVE CRISIS INTERVENTION (Children & Youth)

VIII.B.1. Intensive Crisis Intervention Services for children and youth refer to specialized, time-limited interventions, available twenty-four (24) hours, seven (7) days/week, from some providers through program grants from the Mississippi DMH, Division of Children and Youth.

VIII.B.2. Expected outcome of intensive crisis intervention services for children and youth is a child/youth experiencing a crisis obtains the support needed in order to diffuse the crisis in a manner that will maintain the child/youth in his/her home and community setting.

VIII.B.3. Providers that receive special grant funding from the Mississippi DMH, Division of Children and Youth for Intensive Crisis Intervention Services, must also comply with Emergency/Crisis Services standards (Part VIII, Section A) and any additional specifications set forth in individual program grants.

VIII.B.4. Providers of Intensive Crisis Intervention Services must, at a minimum, provide access to Case Management and Outpatient Mental Health Therapy Services.

VIII.B.5. Providers must include documentation in the child/youth's chart that they have entered Intensive Crisis Intervention Services and must have a plan in place for transition into individual services.

SECTION C- ACUTE PARTIAL HOSPITALIZATION SERVICES

VIII.C.1. Acute Partial Hospitalization is a program that provides 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. Acute Partial Hospitalization 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. Acute Partial Hospitalization may be provided to children with serious emotional disturbance and/or intellectual /developmental disabilities or adults with serious and persistent mental illness or intellectual/developmental disabilities.

VIII.C.2. Expected outcomes of acute partial hospitalization services include:

a. Individuals will be diverted from inpatient stays.
b. If inpatient hospitalization occurs for an individual, the stay will be shorter than previous stays.

VIII.C.3. The Acute Partial Hospitalization Program must be a part of a written comprehensive plan of crisis stabilization and community support services that includes, at a minimum, family interventions, intensive case management, medication monitoring, and other community support activities. The partial hospitalization program must be designed to assist individuals in making the transition from acute inpatient services, and/or serve as an alternative to inpatient care.

VIII.C.4. There must be written policies and procedures implemented for providing Acute Partial Hospitalization Services that include at a minimum:

a. 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.

b. Procedures requiring documented medical supervision and follow along with on-going evaluation of the medical status of the individual.

c. Procedures requiring documented support services for families and significant others.

d. Procedures implementing and documenting discharge criteria to include follow-up planning.

VIII.C.5. The staff for the Acute Partial Hospitalization Program must include at each site a full time director who plans, coordinates, and evaluates the program.

VIII.C.6. Acute Partial Hospitalization Staff must meet the following minimum requirements:

a. 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. (Staff can be the Program Director who is on site.)

b. 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.

c. 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.

VIII.C.7. The Acute Partial Hospitalization 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). These services must be documented through an implemented written procedure carried out by the certified DMH/C provider or through contractual agreement.

VIII.C.8. The Acute Partial Hospitalization Program can be operated seven (7) days per week, but must at minimum:

a. Operate three (3) days per week;

b. Operate four (4) hours per day, excluding transportation time; and

c. Be available twelve (12) months per year.

VIII.C.9. The Acute Partial Hospitalization 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 Acute Partial Hospitalization Program may only go beyond thirty (30) service days with written justification provided by the attending physician. Stays longer than sixty (60) service days in any year must be justified to the DMH and written approval from the Department must be included in the individual's record.

VIII.C.10. The provider must maintain a daily schedule of therapeutic activities to include individual, group, family, and other activities.

VIII.C.11. The facility must have sufficient space to accommodate the full range of program activities and services and must provide a minimum of eighty (80) square feet of multipurpose space for each individual served.

PART IX

CASE MANAGEMENT SERVICES

IX.CM. Case Management Services are included in the minimum required services that must be provided by entities certified as DMH/C. Case Management Services must be made available by providers designated as DMH/C to the following populations: adults with serious mental illness, children/youth with serious emotional disturbance, and individuals with intellectual/developmental disabilities. Additionally, School Based Services, Mental Illness Management Services and Individual Therapeutic Support Services are considered types of case management services.

SECTION A- GENERAL CASE MANAGEMENT SERVICES

IX.A.1. Case Management is the provision and coordination of services that are an integral part of helping individuals access needed medical, social, educational, and other services in order to attain their highest level of independent functioning. Activities include individual's identification, assessment, reassessment, service planning, referral, service delivery monitoring, and supportive counseling as well as outreach services designed to seek out and engage persons who are for eligible for case management.

IX.A.2. Expected outcomes of case management services include:

a. Individuals return to their highest level of functioning.
b. Individuals achieve community inclusion and service goals through linkage to service and natural supports.
c. Individuals decrease their need for services.

IX.A.3. The following individuals with serious mental illness and children/youth with serious emotional disturbance must be evaluated for the need of case management and provided case management, if needed based on the evaluation, unless the service has been rejected in writing by the individual evaluated.

a. Adults who have a serious mental illness or children/youth with serious emotional disturbance and receive substantial public assistance. (public assistance is defined Medicaid);

b. Adults with serious mental illness referred to the community mental health center after discharge from an inpatient psychiatric facility;

c. Children/youth with a serious emotional disturbance who are receiving intensive crisis intervention services; and

d. Children/youth with a serious emotional disturbance referred to the community mental health center after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes (within two weeks of referral for community mental health services).

IX.A.4. Case management must be offered to individuals with serious mental illness, intellectual disabilities/developmental disabilities, legal guardians of youth with serious emotional disturbance at a minimum, every twelve (12) months. Refusals of services must be documented in writing.

IX.A.5. The provider must document involvement of the individual's family in case management services when appropriate.

IX.A.6. Providers of case management services must at a minimum:

a. Have an established case management unit with a full-time Director of Case Management Services;

b. Assign a full time, DMH certified case manager for each individual enrolled in case management;

c. Maintain a list of each case manager's case load that must be available for review by DMH staff;

d. Maintain a current, comprehensive file of available community resources that is readily accessible to all case mangers. This resource file must include at a minimum:

(1) Name of agency;
(2) Eligibility requirements;
(3) Contact person;
(4) Services available; and,
(5) Phone number of the resource agency.

IX.A.7. Individuals receiving case management services with whom no contact has been reported for twelve (12) months must be closed after a documented effort has been made to contact the individual.

SECTION B- ADULT SMI CASE MANAGEMENT

IX.B. In addition to meeting the standards outlined in Section A– General Case Management Services, providers of Adult SMI Case Management Services must also meet the standards outlined in this section.

IX.B.1. The provider must develop an annual written plan for providing case management services that must include, at a minimum, the following areas:

a. Identification of the target population as established in case management guidelines;

b. Specific strategies to be used for outreach to the target population;

c. Formal and informal linkage and coordination efforts with appropriate services in the community, including referral process;

d. Monitoring and follow-up.

IX.B.2. The case management program must have implemented written policies and procedures assuring that individuals being discharged from inpatient psychiatric care are provided an evaluation to determine the need for case management services within two weeks of referral to community services.

IX.B.3. Providers must adhere to the following Case Load Options:

a. Option 1 – Regular case load, maximum of forty (40) individuals;

b. Option 2 – Combination of regular and follow-along, maximum of sixty (60) individuals to be composed of no more than twenty (20) regular and forty (40) follow-along,

c. Option 3 – Follow-along only, maximum of eighty (80) individuals.

IX.B.4. Providers must utilize the following framework to support the frequency of case management contacts:

a. High – at least once every seven (7) days;

b. Moderate – at least twice every fourteen (14) days;

c. Low – at least once every thirty (30) days; and

d. Follow Along – at lease once every ninety (90) days.

IX.B.5. The service plan must clearly state and justify the frequency of contact.

SECTION C- CHILDREN/YOUTH CASE MANAGEMENT SERVICES

IX.C. In addition to meeting the standards outlined in Section A– General Case Management Services, providers of Children/Youth Case Management Services must also meet the standards outlined in this section.

IX.C.1. Efforts to obtain input into the development of the case management service plan(s) of youth enrolled in case management from the following representatives must be documented:

a. Representative(s) of the Mississippi Department of Human Services (DHS) for children/youth in DHS custody our under their supervision;

b. Representative(s) of the child's/youth's local school.

IX.C.2. Input of the parents in the development of the case management service plan from parent(s)/legal guardian(s) of youth enrolled in case management must be documented.

IX.C.3. The written policy and procedure manual for the operation of case management services must also include the following areas:

a. Specific strategies to be used for outreach to the target population for case management services;

b. Formal and informal linkages and coordination efforts with appropriate services in the community, including referral process(es).

IX.C.4. Parent(s)/legal guardian(s) of children/youth being discharged from public inpatient psychiatric care must be offered an evaluation to determine the need for case management services within two weeks after referral for community services**.**

IX.C.5. The case load for a single case manager must not exceed fifty (50), this includes combined case loads of SMI/SED.

SECTION D- INTELLECTUAL/DEVELOPMENTAL DISABILITIES

CASE MANAGEMENT SERVICES

IX.D In addition to meeting the standards outlined in Section A– General Case Management Services, providers of Intellectual/Developmental Disabilities Case Management Services must also meet the standards outlined in this section.

IX.D.1. Face-to-face contact must, at a minimum, be conducted on an annual basis with each individual receiving service.

IX.D.2. Providers must adhere to the following Case Load Options:

a. Option 1 – High- maximum of forty (40) individuals;

b. Option 2 – Moderate – maximum of sixty (60) individuals;

c. Option 3 – Low – maximum of eighty (80) individuals;

d. Option 4 – Combination – Maximum of fifty (50) individuals.

IX.D.3. Providers must utilize the following framework to support the frequency of case management contacts:

a. High- one to four times a month;

b. Moderate – once a month to once a quarter;

c. Low – once a quarter to once a year.

IX.D.4. Potential/Temporary Case Management Services should be provided to individuals while they are in the process of being enrolled into permanent case management or to individuals who do not need ongoing case management but have an immediate need for a service. Potential/Temporary Case Management Services can not exceed 120 calendar days.

SECTION E- SCHOOL BASED SERVICES (CASE MANAGEMENT SERVICES)

IX.E.1. School-Based Services are professional therapeutic services provided in a school setting that are more intensive than traditional case management services and include consultation and crisis intervention. School-Based Services may be provided to children with serious emotional disturbance and children with intellectual /developmental disabilities.

IX.E.2. Consultation, offered through School Based Services, consists of professional advice and support provided by a therapist to a child's teachers, guidance counselors, and other school professionals, as well as to parents, community support providers, treatment teams, court systems, etc. Consultation may be provided as a form of early intervention when no formal treatment process has been established. Parent and/or teacher conferences are included in this service component.

IX.E.3. Crisis Intervention, offered through School Based Services, consists of therapeutic engagement during the school day at a time of internal or external turmoil in a child's life with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and/or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.

IX.E.4. Expected outcomes of School Based Services include:

a. Child/youth's immediate personal distress is alleviated by assessing the precipitants that produced the crisis.
b. Child/youth's future crises are mitigated.
c. Child/youth is able to remain in the classroom setting.

IX.E.5. Individuals receiving school based services must meet eligibility requirements for one or more of the following service categories:

a. Children who are determined to have a serious emotional disturbance (SED);

b. Children with intellectual/developmental disabilities.

IX.E.6. It is not necessary that a child/youth be receiving traditional case management services in order to receive School-Based Services.

IX.E.7. The provider of School-Based Services must develop, compile, and implement an annual written plan for providing school based services that must include a description of how the following services will be provided:

a. Collateral contacts with teachers, guidance counselors, therapists (i.e. speech, physical, etc.), medical personnel, special education teachers, and other school professionals, as well as parents, community service providers, treatment teams, and court systems to enhance coordination of services on behalf of the child.

b. Consultative services to address issues such as increasing interpersonal skills, managing noncompliant behavior, early intervention to minimize maladaptive behaviors, and recognizing the need for more intensive treatment and making referrals.

c. Consultation with parents centered on clarifying individual needs and assisting in accessing services on behalf of the child.

d. Consultation through conferences with parents/legal guardians, teachers, guidance counselors, therapists, medical personnel, special education teachers, and/or other school professionals.

e. Crisis resolution services to address issues that require immediate intervention in the school or family setting. Crisis Resolution Services can also provide interventions where their involvement relates directly to the identified needs of the child (e.g., understanding ADHD).

f. Crisis resolution strategies that are employed to reduce the immediate distress, to assess the precipitant(s) that resulted in the crisis, or, to reduce the chance of future crisis situations through the implementation of preventative strategies.

IX.E.8. School-Based Services must be clearly distinguishable and separate from the educational components required by the school. Educational interventions are not considered part of School-Based Services.

IX.E.9. There must be a written agreement on file between the provider and the school in which School-Based Services will be provided. This agreement must include a statement of confidentiality between the school-based therapist and involved school personnel.

IX.E.10. Children/youth who are actively enrolled in school, but temporarily out of school (e.g. suspensions, illness) remain eligible for this service. Children/youth who are not actively enrolled in school or who are not enrolled in a DMH certified program (e.g.; admitted to inpatient psychiatric care) are not eligible for this service.

IX.E.11. The content of the consultative session or any collateral meeting regarding the child must be documented in a progress note. The activities must be within the service content described in Standard IX.E.7)

IX.E.12. The title and/or position of the person/persons involved in the consultative session must be documented in the progress note.

SECTION F- MENTAL ILLNESS SERVICES (MIMS)

IX.F.1. Mental Illness Management Services (MIMS) are intensive case management services with a therapeutic focus. MIMS may be provided to children with SED and children with I/DD children or adults with SMI and adults with I/DD adults in their current living situation, natural environment, and other appropriate community settings. The scope of Mental Illness Management Services is sufficient to ensure ongoing evaluation and control of psychiatric symptoms while restoring functioning necessary for successful community living.

IX.F.2. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the providers, required to effectively address the more complex mental health needs of the individual receiving the service. Additionally, MIMS provides indirect services to support program participants in the community (i.e., family support, collaboration of other programs/services).

IX.F.3. The expected outcome of MIMS is that the individual's psychiatric symptoms are alleviated in order for the individual to maintain successful community living.

IX.F.4. The provider must develop and implement written policies and procedures for providing MIMS that must at a minimum:

a. Describe how the target population is identified.

b. Describe what services will be included in MIMS to address the following:

(1) Symptom evaluation and monitoring.

(2) Intervention and assistance with resolution of crisis situations.

(3) Provision/enhancement of environmental supports.

(4) Prevention of the need for more intensive treatment services.

(5) Other services/activities designed to increase/prompt independence.

c. Describe how MIMS is coordinated with other case management services, crisis services, and other community support system activities.

d. Defines the credential (Master's degree-see Standard VI.C.1 (l)) of the direct service provider.

IX.F.5. The MIMS Program Director and a physician must certify the necessity of treatment and the appropriateness of care with a signature and date on the Individual Service Plan.

IX.F.6. The MIMS Program Director and assigned MIMS service provider must reevaluate the individual's need for continued service at a minimum of every six (6) months while the individual is receiving MIMS. Documentation to support the need for continuation of services must be indicated in a progress note. This certification of need for continued treatment must be justified in the record and be confirmed by the MIMS Program Director and physician's signatures on the Individual Service Plan.

IX.F.7. MIMS Program Directors must have (1) administrative experience; (2) meet educational as outlined Standard VI.C.1 (a) and (3) hold a professional license or DMH credentials as mental health or intellectual/developmental disabilities therapist.

IX.F.8. The Individual Service Plan must be individualized and address needs for intensive services identified in the intake/assessment. These services can include symptom evaluation/monitoring, group and therapeutic intervention, supportive counseling and crisis management, provision enhancement of environmental supports, and other services directed toward helping the individual live successfully in the community.

IX.F.9. The program must have a process for the evaluation of the individual at least every six months to determine the individual's readiness to resume regular case management services.

IX.F.10 A discharge summary for closed cases must be maintained in the case record, as described in Standard IV.H.7(i), including staff responsible for continuation of services included in the Discharge Plan.

IX.F.11. The caseload assignments of individual staff providing MIMS are as follows:

a. Full-time MIMS provider-maximum of thirty (30) individuals.

b. Combination of duties to include MIMS - maximum of fifteen (15) individuals.

SECTION G- INDIVIDUAL THERAPEUTIC SUPPORT SERVICES

IX.G.1. Individual Therapeutic Support Services are the provision of one-on-one supervision of the individual during a period of extreme crisis in which hospitalization would be necessary without this service. The service may be provided in the individual's home, school, or any other setting that is part of his/her environment. The focus is on the reduction/elimination of acute symptoms.

IX.G.2. The expected outcome of Individual Therapeutic Support Services is for the individual's acute symptoms are managed in the individual's natural environment and hospitalization is diverted.

IX.G.3. Individuals receiving Individual Therapeutic Support Services must meet eligibility requirements for one or more of the following service categories:

a. Adults who are determined to have a serious mental illness (SMI).

b. Children and youth who are determined to have a serious emotional disturbance (SED).

c. Individuals (adults or children) with intellectual/developmental disabilities (ID/DD).

IX.G.4 Individual Therapeutic Support Services provide one-on-one brief interaction in environments that are extremely stressful for the individual on a scheduled short-term basis to observe the individual and to assist them in transition back into integrated settings. Staff providing Individual Therapeutic Support Services must have a high school diploma or GED.

IX.G.5. Supervision of staff providing Individual Therapeutic Support Services must be provided by a staff member with a Master's degree in a mental health or related behavioral health field and professional license or appropriate DMH credentials.

IX.G.6. A supervisor must maintain documentation of direct supervision (contact) of the staff providing Individual Therapeutic Support Services, at a minimum, once per day.

IX.G.7. Each contact must be recorded in a progress note and must include the total amount of time spent with the individual receiving individual therapeutic support.

IX.G.8. The need for Individual Therapeutic Support Services must be justified in the individual's Comprehensive Individual Service Plan.

PART X

PSYCHOSOCIAL PROGRAMS

Psychosocial Rehabilitation Services are therapeutic activity programs provided in the context of a therapeutic milieu in which individuals can address personal and interpersonal issues with the aim of achieving/maintaining their highest possible levels of independence in daily life. Psychosocial Services include: Psychosocial Rehabilitation/Clubhouse Services, Senior Psychosocial Rehabilitation, Day Support, and Day Treatment Services.

SECTION A- PSYCHOSOCIAL REHABILITATION/CLUBHOUSE SERVICES

X.A.1. Psychosocial Rehabilitation/Clubhouse is a community support service for people with serious mental illness which consists of a network of services that help the service recipient develop the potential to live independently and/or become employed. Psychosocial rehabilitation/clubhouse is a program of structured activities designed to support and enhance the role functioning of individuals with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental 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, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

X.A.2. Expected outcomes of Clubhouse Services include:

a. Individuals served will remain in the community setting.
b. Individuals' reliance on inpatient hospitalization will be reduced.
c. Individuals' reality orientation, social adaptation, physical coordination, daily living skills, time/resource management and task completion skills of individuals will improve.
d. Individuals' psychiatric symptoms such as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth will be alleviated.
e. Individuals will receive employment training and opportunities of their choosing.
f. Individuals will transition back into the community to achieve and maintain their highest level of recovery.

X.A.3. The program must operate in one location for a minimum of four (4) hours per day, four (4) days per week, excluding travel time.

X.A.4. A Psychosocial Rehabilitation/Clubhouse program must have an annual average daily attendance of more than eight (8) individuals.

X.A.5. All activities of the program must be established around a day which is structured by task activity units. The units provide all individuals an opportunity to participate.

X.A.6. There must be a minimum of two (2) task activity units, which can include but not be limited to:

a. Clerical unit;

b. Kitchen unit;

c. Snack bar unit;

d. Gardening unit.

X.A.7. Transitional and other employment opportunities must be an integral part of the Psychosocial Rehabilitation/Clubhouse service and must be made available to at least 10% of the number of individuals the program is certified to serve. A minimum of one (1) transitional employment placement must be available in a competitive employment setting in the community in which individuals without disabilities are also employed and that is not operated by the provider program.

X.A.8. Recreational and/or social activities must not be conducted during the structured program hours.

X.A.9. The program must have its own identity, including its own name.

X.A.10. The program is to be located in its own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other programs during hours of program operation. The clubhouse is to be designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.

X.A.11. All program space must be accessible to both individuals receiving services and staff. There are to be no "staff-only" or "individual-only" spaces.

X.A.12. The program site must have sufficient space to accommodate the full range of program activities and services and must provide at least fifty (50) square feet of multipurpose space for each individual.

X.A.13. The Psychosocial Rehabilitation/Clubhouse staff must include at each site a full time supervisor (as defined in Standard VI.C.1(c)) who plans, coordinates, and evaluates the psychosocial rehabilitation program.

X.A.14. Psychosocial Rehabilitation/Clubhouse programs must maintain a minimum of one qualified staff member to each eight (8) or fewer individuals the program is certified to serve.

X.A.15. There must be, on file, a written plan and a description of the service that must include but not be limited to the following:

a. The purpose, goals, and objectives;

b. The population to be served, including the number of individuals to be served by location;

c. The physical environment surrounding the program, at each site;

d. Mechanisms to be used to establish members as decision makers in the operation of the service;

e. Plan for developing and maintaining transitional employment placements.

X.A.16. The program must maintain an evaluation system which addresses at a minimum:

a. Total number of members on roll;

b. Daily attendance;

c. Annual attendance by subgroups (age, sex, race);

d. Average length of stay;

e. Reasons for leaving the program (recidivism vs. progression toward community integration);

f. Member satisfaction with psychosocial services;

g. The number and type of transitional employment jobs;

h. The number of individuals participating in transitional employment;

i. The number of hours available in the transitional employment program by placement;

j. The number of hours worked and income earned by each individual participating in the transitional employment program;

k. Degree of individual involvement in decision making.

X.A.17. Individuals must have a method defined by policy and procedures to communicate their desires to the director of the psychosocial/clubhouse and to the Executive Director of the program, and there must be documentation of such communication on site.

X.A.18. Individuals must have the opportunity to participate in all the work of the clubhouse, including orientation, outreach, training, hiring, and evaluation of staff, or documentation requirements.

SECTION B- SENIOR PSYCHOSOCIAL REHABILITATION SERVICES

X.B.1. Senior Psychosocial Rehabilitation is a program of 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.

X.B.2. Expected outcomes of Senior Psychosocial Rehabilitation Services include:

a. Individual's psychiatric symptoms such as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal, and feelings of low self-worth will be alleviated.
b. Individuals' reliance on inpatient hospitalization will decrease.

X.B.3. The program must be designed to serve elderly persons with serious mental illness or elderly persons with intellectual/developmental disabilities who need assistance in socialization, training for daily living skills, use of leisure time activities, or other structured assistance in activities of life.

X.B.4. No individuals under fifty (50) years of age can be considered for the program. 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.

X.B.5. Senior psychosocial programs must have and average daily attendance at least five (5) individuals**.**

X.B.6. For programs located in a community mental health center, 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**.**

X.B.7. 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.

X.B.8. The service must have a written schedule of daily activities on file, which should include individual therapy, group therapy, family therapy, socialization activities, activities of daily living, and recreational activities.

X.B.9. The services must have activities and physical surroundings that are age appropriate.

X.B.10. The facility must have sufficient space to accommodate the full range of program activities and services and must provide at least sixty (60) square feet of usable space for each individual. (Programs that were operating before July 1, 1999 will be required to have at least 50 square feet per person. Should the program site be changed or if expansion of the existing facility is made to increase the certified capacity, then the program must meet the sixty (60) square foot requirement.)

X.B.11. Staff must be assigned full time to the Elderly Psychosocial Rehabilitation service.

X.B.12. The staff must include at each site a full time **supervisor (**as defined in Standard VI.C.1 (c)) who plans, coordinates, and evaluates the service.

X.B.13. Senior Psychosocial Rehabilitation Services staffing patterns must meet the following minimum requirements:

For programs located in a community mental health center:

a. At least one (1) staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field must be on-site for eight (8) or fewer persons for which the program is certified to serve. (Staff can be the Program Supervisor.)

b. At least one (1) staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field and one (1) support staff for every eight (8) participants served after the initial eight (8) participants.

For programs located in a nursing home:

a. At least one (1) staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field must be on-site for six (6) or fewer persons for which the program is certified to serve. (Staff can be the Program Supervisor.)

b. At least one (1) staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field and one (1) support staff for every six (6) individuals served after the initial six (6) participants.

X.B.14. A medical screening must be conducted of each individual within thirty (30) days prior to admission and once each year thereafter.

SECTION C- DAY SUPPORT (PSYCHOSOCIAL REHABILITATION) SERVICES

X.C.1. Day Support must provide structured, varied and age appropriate activities (both active and passive) and the option for individuals to make choices about the activities in which they participate. The activities must be designed to support and enhance the individual's independence in the community through the provision of structured supports. Program activities must aim to improve social adaptation, physical coordination, daily living skills, employment awareness, and task completion.

X.C.2. Expected outcomes of Day Support Services include:

a. Individual's reality orientation, social adaptation, physical coordination, daily living skills, time/resource management and task completion skills of individuals served will improve.
b. Individual's psychiatric symptoms such as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth will be alleviated.

X.C.3. Day Support Services must include, at a minimum;

a. Community integration and job exploration

b. Job skills training;

c. Leisure-time activities training;

d. Daily social skills training;

e. Coping skills training;

f. Improvement of the individual's current abilities and skills.

g. The capacity for personal growth;

h. The enhancement of self-image;

i. Assistance with maintaining and learning new skills which promote independence;

j. Assistance with developing interpersonal relationships;

k. Assistance with eliminating isolation; and,

l. Assistance with improving physical and emotional well being.

X.C.4. Individuals receiving Day Support Services must meet eligibility requirements for one or more of the following service categories:

a. Adults with a serious mental illness (SMI) diagnosis.

b. Adults with intellectual/developmental disabilities (ID/DD).

c. Individuals (adults) with a substance abuse diagnosis and with a history of substance abuse.

X.C.5. 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.

X.C.6. 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**.**

X.C.7. 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.

X.C.8. Written policies and procedures, including a description of the program, must be maintained and must include, but not be limited to, the following:

a. The purpose, goals, and objectives of the program;

b. 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 in a Clubhouse or a Work Activity Center, but still need structured daily activities.

c. The daily hours of operation and number of people to be served at each program site.

d. Description of the daily activities to be available.

SECTION D- DAY TREATMENT SERVICES

X.D.1. Day Treatment is the most intensive outpatient program available to children and adolescents. It should provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides children/adolescents with serious emotional/behavioral disturbances and/or intellectual/developmental disabilities the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants in a particular program and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

X.D.2. Expected outcomes of Day Treatment Services include:

a. Individuals served in Day Treatment programs will transition to a less intensive therapeutic service and/or environment.

b. Individuals served in Day Treatment programs will transition to the regular classroom setting.

The Standards that follow pertain to ALL providers of Day Treatment Services.

X.D.3. Individuals being served must meet all requirements which determine the eligibility for the services being provided.

a. Criteria for the following must be met: Serious Emotional Disturbance, Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Alcohol and Drug Addiction/Abuse, Intellectual/Developmental Disabilities.

b. Justification of the need for Day Treatment services, including intensity and duration of problems, must be documented as part of the intake/assessment or as part of a post-intake case staffing and annually thereafter. Documentation must 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.

X.D.4. At a minimum, one (1) children's Day Treatment Program must be available at a school site in each school district in the region served by a Community Mental Health Center.

X.D.5. Each 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 must receive Day Treatment services 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.

X.D.6. To ensure each child's confidentiality, no children other than those enrolled in the Day Treatment Program can be present in the room during the time Day Treatment is being provided.

X.D.7. Only one (1) Day Treatment Program is allowed per room during the same time period.

X.D.8. Each Day Treatment Program must operate under separate DMH Certificates of Operation.

X.D.9. The Day Treatment Program Director (as defined standard VI.C.1(a)) or their designee (as approved by the DMH) must supervise, plan, coordinate, and evaluate Day Treatment services. Supervision must be provided at least one continuous hour per month. In addition, the Day Treatment Program Director

or their designee must provide at least 30 continuous minutes of direct observation to each Day Treatment Program quarterly. Documentation of the supervision/observation must be maintained for review.

X.D.10. The DMH Division of Accreditation and Licensure must be notified immediately of any interruption of service with a Day Treatment Program extending over thirty (30) days. If operation has been interrupted for sixty (60) calendar days, the DMH Certificate of Operation must be returned to the DMH Division of Accreditation and Licensure.

X.D.11. Day Treatment Programs are intended to operate year-round and can not be designed to operate solely during the summer months.

X.D.12. Day Treatment Programs that are unable to provide school-based services during a school's summer vacation will be allowed to hold that program's Certificate of Operation until the program 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 Accreditation and Licensure.

X.D.13. Day Treatment Programs that do not meet during summer vacation must offer services for the child/youth to the parent(s)/legal guardian(s) for the period that the Day Treatment Program is temporarily not operational. Documentation must be maintained that availability of other services was explained and offered to the parent(s)/legal guardian(s).

X.D.14. Day Treatment Programs operated in a school must ensure that Day Treatment Services continue to adhere to all DMH Operational Standards for MH/IDD/SA Community 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 conducted concurrently.

X.D.15. 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 should 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 individual's comprehensive Individual Service Plan.

X.D.16. Each Day Treatment Program must operate at any one time with a minimum of four (4) and a maximum of nine (9) children/youth. A Day Treatment roll/roster can not exceed nine (9) children/youth per Program.

X.D.17. Each Day Treatment Program (four to nine children) 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 of individuals receiving services must be listed for all individuals participating in each skill area (time period) being addressed.

X.D.18. Each Day Treatment Program must comply with the following:

a. A minimum of twenty square feet of usable space per child;

b. In cases of school-based programs, the mental health provider is responsible for ensuring that the school district provides a site or facility that meets all standards in Part VII - Environment/Safety. 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.

c. Furnishings, equipment, square footage and other aspects of the Day Treatment environment must be age-appropriate, developmentally appropriate, and therapeutic in nature.

X.D.19. The ratio of staff to individuals 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 nine (9) children/youth per program. The program must be led by a Day Treatment Specialist (as defined in Standard VI.C.1(j)). Day Treatment Assistants (as defined in Standard VI.C.1(p)) serve as the second needed staff in this ratio.

X.D.20. Transitional procedures must be included in the Individual Service Planning for all children/youth participating in Day Treatment Programs. Documentation of plans for transitioning a child to a less intensive therapeutic service when deemed clinically appropriate must be maintained in each child's record.

Day Treatment Services for Children/Youth with Intellectual /Developmental Disabilities

X.D.21. In addition to meeting all requirements and standards included in Section D (Standards X.D.1 through X.D.21.), providers of Day Treatment to children/youth with Intellectual or Developmental Disabilities must document the justification of the need for Day Treatment services for children with ID/DD as part of the intake/assessment. Documentation must include, at a minimum; Psychological Testing, ID/DD Eligibility Certificate. There must also be an Individual Education Plan for school aged children that directly relates to the Individual Service Plan.

Day Treatment Services for Children/Youth with Alcohol and/or Drug Dependence or Abuse

X.D.22. In addition to meeting all requirements and standards included in Section D (Standards # X.D.1 through X.D.21), providers of Day Treatment to children/youth with alcohol and/or drug dependence or abuse must:

a. Operate for at least ten (10) weeks for each adolescent.

Day Treatment Services for Pre-K

X.D.23. 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. These standards are in addition to the previous standards required for all day treatment programs.

X.D.24. All children must be signed in and out of the program by a parent/legal guardian. If child is being transported by the program staff, the parent/legal guardian must sign the child on and off of the van. The parent/legal guardian 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 guardian, written permission from the parent/legal guardian must be in the child's chart. Sign In/Out documentation must be available for review.

X.D.25. Chairs and tables used in the day treatment room must be appropriate to the size and age of the children. This furniture must be kept clean with frequent disinfection.

X.D.26. 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.

X.D.27. All children participating in day treatment must be age-appropriately immunized and must have, on file, a Certificate of Immunization Compliance (MSDH Form 121) that has been signed by the District Health Officer, a physician, nurse or designee.

X.D.28. Any child who is suspected of having a contagious condition must be removed from the day treatment room and returned to the parent/legal guardian as soon as possible. The child will not be allowed to return to the day treatment room until they have been certified by a physician to no longer be contagious. Conditions that would require exclusion from the program include fever, diarrhea, vomiting, rash, and sore throat if accompanied by a fever and eye discharge.

X.D.29. 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.

PART XI

COMMUNITY LIVING

Community Living Services encompass any type of provider offered living arrangements and/or services. There are three core types of Community Living Services: Supported Living, Supervised Living and Residential Treatment. The level/type of service is dependent upon the needs of the individuals in the service.

SECTION A- TYPES OF COMMUNITY LIVING SERVICES

XI.A.1. Supported Living. The provider has necessary staff to support the individual in the community who needs less than twenty-four (24) hours per day/seven (7) days per week support. Supported Living is the most integrated community living service available. Services offered under Supported Living include:

a. Home and Community Supports (HCS). These services are available to individuals with Intellectual/Developmental Disabilities participating in the ID/DD Waiver. *(This service was referred to as ID/DD Waiver Attendant Care Services and ID/DD Waiver Supported Living in the 2002 DMH Standards.)*

b. Therapeutic Foster Care (TFC). These services are only available to children/youth with serious emotional disturbance.

c. Supported Housing. Supported Housing services are available to adults with serious mental illness and individuals with Intellectual/Developmental Disabilities who do not participate in the ID/DD Waiver program. *(This service was referred to as IDD Supported Living and MH Supervised* ***Housing.)***

XI.A.2. Supervised Living. The provider has necessary resources to support the individual in the community with twenty-four (24) hour/seven (7) days per week staffing coverage. Supervised Living is an intermediate level of community living service that is available. Services offered under Supervised Living include:

a. Supervised Living. This service is available to individuals with Intellectual and/or Developmental Disabilities.

b. Therapeutic Group Homes (TGH). This service is available to children/youth with serious emotional disturbance.

c. Transitional Residential. This service is available to individuals seeking Substance Abuse Prevention and Rehabilitation services.

d. Halfway House. This service is available to adults with serious mental illness.

e. Group Homes. This service is available to adults with serious mental illness.

XI.A.3. Residential Treatment. The provider has necessary resources to support the individual's treatment twenty-four (24) hours a day/seven (7) days per week with staffing coverage. The individual also remains on site twenty-four (24)/seven (7) (except school hours for C&Y). This is the most restrictive level of care available in the community.

a. Crisis Residential. This service is available to children and youth with serious emotional disturbance.

b. Chemical Dependency Units. This service is available to individuals seeking Substance Abuse Prevention and Rehabilitation Services.

c. Primary Residential. This service is available to individuals seeking Substance Abuse Prevention and Rehabilitation Services.

d. Crisis Stabilization Units (CSU). This service is available to adults with serious mental illness.

SECTION B- PROGRAM MANUALS

XI.B.1. All providers of Community Living Services (all types) must develop a program manual which includes all policies and procedures of the service. The program manual must be on-site and updated as needed. At a minimum, the program manual must address the following:

a. A definition of the service being provided;

b. The philosophy, purpose and overall goals of the service, to include but are not limited to:

(1) Method for accomplishing stated goals and objectives.
(2) Expected results/outcomes.

(3) Methods to evaluated expected results/outcomes.

c. Admission to the services;

d. Description of the program's components or services, including the minimum levels of staffing required for the protection and guidance of individuals to be served in the program;

e. A description of therapeutic modalities and treatment activities (including age-appropriate activities) to be provided (if any) and a schedule of these activities;

f. A description of the meals and snacks to be provided, to include but not limited to;

(1) Development of menu (with residents input);
(2) Insurance of varied, nutritious meals and snacks; and
(3) Preparation of meals and snacks.

g. A description of the program rules, to include but not limited to;

(1) Visitation (including restricted visitors);
(2) Communication (phone, mail, email, etc.);
(3) Dating;
(4) Off-site Activities;
(5) Household Tasks;
(6) Curfew;
(7) Use of Alcohol, Tobacco and other Drugs; and
(8) Respecting the rights of other residents' privacy, safety, health and choices.

h. Collection of fees, to include but not limited to;

(1) Basic charges;
(2) Time frame covered by charges;
(3) Special service charges;
(4) Refund of charges/deposits; and
(5) Written financial agreement.

i. Room, person and/or possession searches, 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.

j. Prohibited substance screening, 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.

k. Orientation to Community Living services, to include but not limited to;

(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.); and
(4) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any applicable program rules prior to or at the time of admission.

l. Routine and emergency medical and dental care, to include but not limited to;

(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.

m. Responsibility of the staff for implementing the protection of the individual and his/her personal property and rights;

n. The need for and development, implementation and supervision of behavior change/management programs;

o. Risk assessment and mitigation;

p. Personal hygiene care and grooming;

q. Prevention of and protection from infection, including communicable diseases;

r. Medication management; and

s. Discharge criteria.

XI.B.2. A pet policy must be addressed in the agency's policy and procedures manual and program manual for all providers/programs that maintain animals on their property. The policy must address, at a minimum, the following:

a. Pets must be vaccinated again rabies and all other diseases communicable to humans (vaccination records must be maintained on site).

b. Pets must be kept in a sanitary manner and away from food preparation sites or eating areas.

c. Pets must be controlled to prevent injury of individuals receiving services, staff, or visitors.

SECTION C- SPECIFIC REQUIREMENTS FOR COMMUNITY LIVING SERVICES FOR CHILDREN AND YOUTH

XI.C.1. Each child/youth 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.

XI.C.2. All Community Living programs for children and youth 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:

a. Social skills development;
b. Anger management;
c. Wellness education;
d. Increasing self-esteem;
e. Leisure activities;
f. Substance abuse education/counseling;
g. HIV/AIDS education and/or counseling; and
h. Sexually Transmitted Diseases.

XI.C.3. The provider must maintain updated daily and weekly schedule(s) of activities that reflect group activities and routines, as well as individually planned

activities for the children and youth served in the Community Living program. Daily and weekly schedule(s) of activities must be maintained on file for at least three (3) months. Group activities must be related to implementation of objectives in the Individual Service Plans of children and youth served in the program.

XI.C.4. The program must obtain a permission form, signed by the parent or legal guardian, for the child/youth to participate in specific program activities off the program site.

XI.C.5. Children/youth must have a dental examination within sixty (60) days after admission and annually thereafter. Evidence of a dental examination within the twelve (12) months prior to admission may take the place of a dental examination within sixty (60) days after admission.

SECTION D- HANDBOOK REQUIREMENTS

XI.D.1. All providers of Community Living Services (all types) must develop a handbook to be provided to the individual/parent/guardian during orientation which must address at a minimum the following:

a. An explanation of the services, activities, performance expectations, substance use (including alcohol) policy and any other rules and regulations;
b. An explanation of the rights of individuals served by the program; and

c. An explanation of the program's policies regarding respecting the rights of other residents' privacy, safety, health and choices;

d. An explanation of any fees and how the fees are collected;

e. An explanation of the circumstances for an individual's room, person and/or possessions to be searched;

f. An explanation of the circumstances for an individual to be required a prohibited substance screen, the consequences of a positive screening for prohibited substances and the consequences of refusing a prohibited substance screen;

g. An explanation of routine and emergency medical and dental treatment;

h. An explanation of educational and vocational opportunities; and

i. Review of visitors, callers, relatives, or others who are identified as required "no contact" or counter therapeutic with the resident**.**

j. For provider of Children/Youth Community Living Services, policies and procedures regarding dating, description of out of facility activities, and the expectations regarding participation of parents/legal guardians in treatment.

XI.D.2. All providers of Community Living Services (all types) must comply, at a minimum, with the following:

a. The provider 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; and

b. The provider must document input from residents regarding the development of all sections of the handbook.

SECTION E- FEE AGREEMENTS

XI.E.1. A written financial agreement in Community Living Services where individuals served pay rent/utilities which must, at a minimum address the following;

a. Include written procedures for setting and collecting fees (in accordance with Standard III.FM.2.);
b. Include a detailed description of the basic charges agreed upon (ex: rent, utilities, food, etc.);

c. Indicate the time period covered by the charges;

d. List the services for which special charges are made;

e. Contain written documentation of the explanation and review with the individual/ parent/legal guardian prior to or at the time of admission and annually thereafter;

f. Contain the signature of the individual and/or legal guardian to indicate agreement with its contents;

g. Be maintained in each person’s record, with a copy of the signed agreement provided to the individual/legal representative; and

h. Be reviewed/revised at least annually or as changes occur.

SECTION F- DISCHARGE REQUIREMENTS

XI.F.1. All providers of Community Living Services (all types) must develop policies and procedures for discharge or termination from the service/program which must, at a minimum, address the following;

a. Reason for discharge;

b. Assessment of progress toward Individual Service Plan or Service/Activity Plan, Needs Assessment/Aftercare Plan or Plan of Care objectives;

c. Discharge instructions given to the individual who received services or their authorized representative, parent(s)/legal guardian(s), including referrals made;

d. Any other information deemed appropriate to address the needs of the individual being discharged from the program.

XI.F.2. Providers of Community Living Services for Children and Youth, must have implemented policies and procedures that ensure that, at a minimum:

a. Children and youth being discharged from services back to placement in the community are given an appointment with a psychiatrist within four (4) weeks after discharge. Discharge can not take place until appointment has been secured;

b. The child/youth (and family member(s) as appropriate) are evaluated for and/or enrolled in case management services within two (2) weeks after referral for community services; and

c. For children and youth in the custody of the MS Department of Human Services, the social worker from the county of residence of the child/youth is provided the opportunity to be in involved in the discharge/placement plans;

d. For children and youth in the custody of the MS Department of Human Services, the child/youth is provided an opportunity for one pre-placement visit prior to discharge.

e. Document that an appointment has been scheduled with the CMHC responsible for services in the county where the youth will reside upon discharge.

SECTION G- SUPPORTED LIVING OPTIONS

Supported Living Options include: Home and Community Supports (HCS), Therapeutic Foster Care Programs for children/youth who have a serious emotional disturbance, Supported Housing Services for adults with serious mental illness and individuals with intellectual/ developmental disabilities.

Home and Community Supports for individuals participating in the ID/DD Waiver Program

XI.G.1. Home and Community Supports offer a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and community, and provide safe access to the community.

XI.G.2. The expected outcome of Home and Community Supports is that people receive the services and supports necessary to remain at home and in the community.

XI.G.3. HCS must consist of one or more of the following types of services, depending on each individual's identified needs:

a. Activities of daily living (ranging from total support in these activities to partial physical support to prompting);

b. Assistance in housekeeping directly related to the individual's health and welfare;

c. Assistance with the use of adaptive equipment; and

d. Support and assistance for community participation, including appointments, banking, shopping, recreation/leisure activities, socialization opportunities.

XI.G.4. HCS cannot be provided in schools or be a substitute for educational services or other day services for which the individual is appropriate (e.g., Day Services-Adults, Prevocational Services, Supported Employment, and/or Work Activity Services).

XI.G.5. 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.

XI.G.6. HCS staff cannot accompany a minor on a medical visit without a parent/legal guardian.

XI.G.7. HCS providers are not permitted to provide medical treatment as defined in MS Nurse Practice Act.

XI.G.8. HCS providers may assist individuals with money management, but cannot receive or disburse funds on the part of the participant. Individuals must maintain their own financial resources according to the following:

a. No staff or agency name can appear on an individual's personal accounts; and

b. No financial transaction can be made if the individual is not present.

Therapeutic Foster Care Programs

XI.G.9. Therapeutic Foster Care (TFC) is an intensive community-based program composed of mental health professional staff and trained foster parents who provide a therapeutic program for children and youth with serious emotional disturbances living in a foster home.

XI.G.10. Expected outcomes of therapeutic foster care programs include:

a. Children/youth in TFC experience an increase in the number of stable placements.
b. Each child/youth in the program has increased biological or adoptive parental involvement in Individual Service Planning and participation in the program in order to promote success of the child/youth's permanency plan.
c. Each child/youth receives needed services and supports through collaboration with other agencies that provide services to children/youth.

XI.G.11. Each therapeutic foster 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 TFC home if the following conditions apply:

a. The siblings have never been separated;

b. The siblings are not a danger to others;

c. The DMH has approved in writing the siblings may be placed together in the same TFC home. This documentation must be maintained in the individual case record of each sibling; and

d. TFC parents asked to place siblings in their home must consent to the placement in writing. This documentation must be maintained in the individual case record of each sibling.

XI.G.12. Each TFC program certified for ten (10) to thirty (30) homes must have a full-time director with overall administrative and supervisory responsibility for the program. If the TFC program is certified for less than ten (10) homes, the director can have administrative or supervisory responsibility for other 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 program.

XI.G.13. Each TFC program certified for ten (10) to thirty (30) homes must have one full-time TFC specialist whose services target the TFC families. The TFC specialist's specific responsibilities must include at least the following:

a. Recruitment and training of therapeutic foster parents;

b. Conducting interviews and other necessary work to appropriately place individual children and youth with prospective therapeutic foster parents;

c. Maintenance of regular contact with TFC families and provide documentation of those contacts in the case records; and,

d. Performance of other family support activities, as needed.

XI.G.14. If the TFC program is certified for less than ten (10) 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 is spent in performing duties of the TFC specialist/case manager. (For example, in a program with two (2) therapeutic foster homes, at least twenty percent (20%) of the assigned staff's time must be spent in performing duties of the therapeutic foster case specialist.)

XI.G.15. TFC programs must provide or contract with a community mental health center or a private practitioner to provide mental health therapeutic services for all children/youth in the program. These services must include individual and family therapy. Group therapy may also be provided.

XI.G.16. A licensed psychiatrist with experience working with children/youth, on an employment or contractual basis must be available for youth served by the TFC.

XI.G.17. Each TFC program must utilize adults with current documentation of foster parent approval by the Mississippi Department of Human Services.

XI.G.18. Each TFC program must have one (1) full-time professionally licensed or DMH credentialed mental health therapist for every twenty (20) therapeutic foster children/youth in the TFC program.

XI.G.19. The mental health therapist(s) for the TFC program must serve only in the mental health therapist role (i.e. cannot serve as the director or the TFC specialist).

XI.G.20. Arrangements must be made for and documentation maintained in the record for children/youth to have a physical examination within thirty (30) days after admission, and annually thereafter.

XI.G.21. Arrangements must be made for and documentation maintained in the record for children/youth to have a psychological or psychiatric evaluation at least annually.

XI.G.22. The mental health therapist must have at least one individual therapy session per week is required with the child or youth. At least one family session per month is required with the foster parent(s).

XI.G.23. The TFC specialist must have face-to-face contact with each TFC parent(s) at least two times per month, with at least one of the two contacts made during a home visit. All TFC program contacts of the TFC specialist with the TFC parent(s) must be documented in the individual case record of the parent(s).

Supported Housing Services

XI.G.24. Supported Housing is a form of housing service that provides a residence for three (3) or fewer individuals in a single living unit. Individuals function with a greater degree of independence than in a supervised living environment. Supported Housing generally has staff responsible for the housing unit. Contacts with the individual are needed on a regular basis of at least several times a month. During the day individuals may engage in activities of the provider program, supported or transitional employment, competitive employment, or other community activities.

XI.G.25. The expected outcome for Supported Housing Services is that individuals gain greater self-sufficiency and move into the most integrated setting in the community, based on their level of needed support.

XI.G.26. If the housing unit is owned and/or operated by the provider, then each housing unit must have:

a. A fire extinguisher that is securely mounted in the kitchen. This fire extinguisher must be regularly checked by staff and must be inspected at least annually to assure that it is operable;

b. Providers must provide evidence that fire extinguishers are being recharged after 6 years;

c. 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

d. 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.

XI.G.27. Training must be provided to adults receiving any type of Supported Housing Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following;

a. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;

a. 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;

b. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature; and

c. Any other health/safety issues based on the needs of each resident.

XI.G.28. Providers who serve individuals who live alone must have at least one (1) qualified staff person on call twenty-four (24) hours per day/seven (7) days per week, in case of emergency and/or to manage unplanned needs which may arise for the individual(s).

XI.G.29. Providers must develop methods, procedures and activities to provide independent living choices for the individual(s).

XI.G.30. Procedures must be developed for individual(s) to access any other needed services in the event of an emergency.

XI.G.31. To the degree possible, the residents must have the authority and responsibility to operate the housing unit as they see fit.

XI.G.32. The Supported Housing activities and physical arrangement must be designed to promote individual independence and encourage independent living.

XI.G.33. The provider must have a method to determine individual satisfaction with the service. This evaluation must include, at a minimum, the satisfaction with location and upkeep of the apartment/residence, the support provided in achieving independence, accessibility to community resources and services, and the ability to make independent decisions. This evaluation must be conducted at least annually, with results on file for review.

XI.G.34. Support must be available as needed to provide:

a. Money management training;

b. Independent living skills training and support;

c. Community resources training and support; and

d. Access to mental health, IDD, health, and other community services.

SECTION H- SPECIFIC REQUIREMENTS FOR ALL SUPERVISED LIVING & RESIDENTIAL TREATMENT PROGRAM OPTIONS

XI.H.1. This section applies to environmental and programmatic requirements that are specific to all Supervised Living and Residential Treatment Program options.

XI.H.2. Bedrooms must meet the following specifications:

a. 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;

b. Resident bedrooms must meet the following dimension requirements:

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

c. Resident bedrooms must house no more than three (3) persons each;

d. 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;

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

f. Single 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;

g. 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;

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. 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 place in a central location outside of sleeping areas.

j. Each bedroom must have at least two means of escape; and

k. 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.

XI.H.3. All providers must ensure that programs have furnishings that are safe, comfortable, appropriate, and adequate.

XI.H.4. 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.

XI.H.5. 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.

XI.H.6. All programs must ensure visiting areas are provided for residents and visitors:

a. Facilities housing less than thirteen (13) residents must have at least one (1) visiting area;
b. Facilities housing thirteen (13) or more persons must have two (2) visiting areas; and
c. Each visiting area must have at least two (2) means of escape.

XI.H.7. All programs must ensure the laundry room has an exterior mechanical ventilation system for the clothes dryer.

XI.H.8. All programs must have separate storage areas for:
a. Sanitary linen;
b. Food (Food supplies can not be stored on the floor.); and
c. Cleaning supplies.

XI.H.9. All programs must ensure an adequate heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

XI.H.10. 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.

XI.H.11. All individuals admitted to Supervised Living or Residential Treatment Programs 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 Supervised Living or Residential Treatment 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.

XI.H.12 The provider must ensure that each individual served in a Supervised Living or Residential Treatment Program(s) has appropriate clean, comfortable, well-fitting clothes and shoes.

XI.H.13. The individuals living in the Supervised Living and Residential Living Programs must be registered as receiving services of the program.

XI.H.14. The program must provide 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. Staff must be able to respond to emergencies at a minimum within five (5) minutes.

XI.H.15. The program must have a full-time supervisor designated exclusively to the program.

XI.H.16. Supervised Living programs must, to the maximum extent possible, duplicate a "home-like" environment.

SECTION I- SUPERVISED LIVING OPTIONS

Supervised Living – Intellectual /Developmental Disabilities

XI.I.1. Supervised community living arrangements provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Learning and instruction are coupled with the elements of support, supervisions 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.

XI.I.2. Expected outcomes for IDD Supervised Living include:

a. Individuals are provided the opportunity to live in the most integrated setting available according to their needed level of support.
b. Individuals are afforded choice of community integration activities.

XI.I.3. A maximum of six (6) individuals may reside in any single apartment or house.

XI.I.4. There must be at least one (1) staff person available for every six (6) individuals served. Additional staff may be required depending on each person's identified level of support.

XI.I.5. Supervised Living services for individuals with an intellectual/developmental disability can be provided in a group home or apartment setting and include;

a. Assisting individuals in monitoring their health and/or physical condition and maintaining documentation of the following in each person's record:

(1) Assistance with making doctor/dentist/optical appointments;
(2) Transporting and accompanying individuals to such appointments; and
(3) Conversations with the medical professional, if the individual gives consent.

b. 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 service plan.

XI.I.6. Each person entering Supervised Living services must participate in an individualized assessment, formal or informal, to be used to develop his/her service plan.

Therapeutic Group Homes – Children and Youth

XI.I.7. The primary mission of Therapeutic Group Homes (TGH) is to provide individualized services to youth with serious emotional disturbances in a structured, therapeutic home environment. Youth served in TGH's need intensive treatment in a community-based setting; however, they do not need services provided in a long-term psychiatric residential treatment center or in an inpatient (acute) hospital setting. Program emphasis in a TGH is on developing or increasing social and independent living skills youth need to make a successful transition to a less restrictive living situation. TGH's typically include an array of therapeutic interventions, such as individual,

group and/or family therapy and individualized behavior management programs.

XI.I.8. Expected outcomes for therapeutic group home services include:

a. Youth will develop independent living skills needed for transitioning to a more integrated living situation.
b. Youth will be diverted from placement in a long-term acute psychiatric or inpatient acute hospital setting.

XI.I.9. The maximum bed capacity of each TGH is ten (10) beds per home for youth twelve (12) years of age and over and eight (8) beds for youth under twelve (12) years of age. 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 youth served by the individual home.

XI.I.10. The TGH facility must be equipped with an operable electronic security system that has the capacity to monitor unauthorized entrance, egress, or movement through the facility.

XI.I.11. 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:

a. 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 every five (5) children or youth during all hours;

b. 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;

c. A full-time director (see requirement Standard VI.C.1) who is on-site at least forty (40) hours per week;

d. Other appropriate professional staff must be available to assist in emergencies, at least on an on-call basis, at all times; and

e. The Mississippi 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.

XI.I.12. A licensed psychiatrist and a professionally licensed or DMH credentialed mental health therapist with experience working with children/youth, on an employment or contractual basis, must be available for child/youth served by the TGH.

XI.I.13. 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.

XI.I.14. Children/youth in the TGH program must receive mental health therapy services sufficient to meet their needs, at least once per week or more frequently if needed. Documentation must be maintained in the case records of the children/youth indicating the progress/results of the mental health therapy services.

XI.I.15. Transition plans must be developed and included in the child/youth's record within ninety (90) days prior to completion of a TGH program.

Transitional Living Services – Substance Abuse and Rehabilitation

XI.I.16. The Transitional Living Substance Abuse Treatment Program provides a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. With group support, individuals acquire coping skills which enable them to become productive citizens in their communities.

XI.I.17. Expected outcomes for Transitional Living Services include:

a. All individuals participating in Transitional Living Services have completed a Primary Treatment Program within thirty (30) days.
b. An eighty-five percent (85%) utilization rate is expected.
c. Individuals are assisted with transitioning back to the community and maintaining a life free from chemical dependency.

XI.I.18. Staffing must be sufficient to meet service requirements. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Bureau of Alcohol and Drug Abuse for approval by the DMH Review Committee.

XI.I.19. An individual must have successfully completed a primary substance abuse treatment program before being eligible for admission into transitional residential services. The primary substance abuse treatment program must be of a duration that consists of a minimum of thirty (30) days.

XI.I.20. The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;
b. At least five (5) hours per week of group counseling which accommodates individual employment schedules;

c. Family counseling;

d. 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;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational, educational, employment or related activities.

XI.I.21. Transitional Living programs serving pregnant and parenting women/legal guardians with young children who reside on the program site must adhere to the following:

a. Adequate, secure, and supervised play space for the children of women served in the program must be provided.

b. 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.

Halfway House Services – Adult Mental Health

XI.I.22. Halfway House Services for individuals with serious mental illness must provide a readjustment and transitional living facility for individuals discharged from a psychiatric hospital who have demonstrated mental, physical, social and emotional competency to function more independently in the community. Halfway House Services may also be provided for individuals who need this service as an alternative to a more restrictive treatment setting.

XI.I.23. Expected outcomes for Halfway Half Services include:

a. Individuals are provided temporary housing for short term observation.
b. Individuals have decreased reliance on inpatient treatment.
c. Individuals are provided choices in access to employment, transportation, and community inclusion activities.

XI.I.24. Staffing must be sufficient to provide service requirements. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of MH Community Services for approval by the DMH Review Committee.

XI.I.25. The provider of the Halfway House program must have a written and implemented plan of service delivery which includes:

a. A schedule of activities or procedures providing access to the following:

(1) At least one hour of individual counseling or two hours of group counseling per week;
(2) At least four hours per week of skills training, e.g., daily living skills, social skills, assertiveness skills, etc;
(3) Family involvement;
(4) Proper medication usage training;
(5) Educational services;
(6) Proper nutrition habits training;
(7) Recreation and social activities;
(8) Prevocational and/or vocational training; and
(9) Orientation to community resources.

XI.I.26. The duration of each resident's stay must not exceed six (6) months without prior written approval. Requests should be directed to the Director, Bureau of Community Services for approval by the DMH Review Committee.

Group Home Services – Adult Mental Health

XI.I.27. Group Home Services for adults with serious mental illness provide residential accommodations in a home-like environment, with supervision and training for adults with a serious mental illness (as defined by the Mississippi DMH).

XI.I.28. Expected outcomes for Group Home Services include:

a. Individuals are prepared to move to more individual/permanent housing options.
b. Individuals have decreased reliance on inpatient treatment.

XI.I.29. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of MH Community Services for approval by the DMH Review Committee.

SECTION J- RESIDENTIAL TREATMENT OPTIONS

XI.J.1. All Residential Treatment facilities (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.

XI.J.2. The Residential Treatment facility (all types) must be equipped with an operable electronic security system that has the capacity to monitor unauthorized entrance, egress, or movement through the facility.

XI.J.3. The Residential Treatment facility (all types) must have emergency exit doors operated by a magnetic/electronic (or similar) release system. This system must be in a readily accessible and in a secured location that is accessible only by staff.

XI.J.4. The Residential Treatment Program (CDU) must meet the licensure and certification requirements of the appropriate responsible agency, as required by state law.

Crisis Residential Treatment Services – Children and Youth

XI.J.5. Crisis Residential Treatment Services (excludes inpatient and psychiatric residential treatment facilities licensed and certified by the Mississippi State Department of Health) provide brief assessment with immediate and intensive residential treatment services, typically followed by intensive outreach/aftercare treatment. Providers that make available a residential

treatment component as part of a comprehensive emergency/crisis response program must meet the standards in this section. Additionally, providers of Crisis Residential Treatment Services for C/Y must also meet the standards in Parts VIII, Sections A and B.

XI.J.6. Expected outcomes for Crisis Residential Treatment Services for C/Y include:

a. Children/youth experiencing a crisis obtains the support needed in order to diffuse the crisis in a manner that will maintain the child/youth in a community residential setting.
b. Children/youth have a decreased reliance on inpatient treatment.

XI.J.7. To ensure that the staff on-site is of a sufficient number to provide adequate supervision of child/youth in a safe, therapeutic environment at least one (1) staff for every four (4) child/youth must be assigned to direct service responsibilities during all hours. At least one (1) staff on duty must be a professional staff member with at least a Bachelor's degree in a mental health or related field.

XI.J.8. The provider must ensure that an adequate number of professional staff are available and on-site and are qualified by training and experience to provide programmatic direction and supervision. The staffing composition pattern will be subject to approval by the DMH Director, Bureau of Community Services, 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 individual homes. The staffing composition of all Crisis Residential Treatment programs must include, at a minimum, the following:

a. A full-time director who is on-site, at least forty (40) hours per week, and who meets the minimum qualifications as stated in Standard VI.C.1(a);
b. Availability of a licensed psychiatrist with experience working with children/youth, on an employment or contractual basis;

c. A full-time mental health therapist who is on-site, at least forty (40) hours per week, and who meets the minimum qualifications as stated in Standard VI.C.1(h).

d. Availability of an additional mental health professional staff person, with at least a Bachelor's degree in a mental health or related field, if needed to meet staffing requirements.

XI.J.9. Children/youth served by the Crisis Residential Treatment program must meet the following eligibility criteria:

a. Under the age of nineteen (19) years and within a developmentally appropriate age range to benefit from the services of the program as specified/determined by the program;

b. Designated staff confirm that the individual is experiencing severe, demonstrable emotional crisis(es) that can be appropriately addressed through the specific services provided by the program; and

c. The condition/situation indicates that Crisis Residential Treatment could divert them from inpatient care or other more restrictive placement.

XI.J.10. Crisis Residential Treatment programs must provide the following services:

a. Medical and psychological evaluation and assessment by appropriately certified individuals of the need for referral to other specialized treatment programs or services (such as alcohol/drug treatment);

b. Psychiatric consultation;

c. Case Management;

d. Family education and counseling; and

e. Access to intensive crisis intervention aftercare.

XI.J.11. Children/youth served by the Crisis Residential Treatment program must, at a minimum, receive an initial individual therapy session within the first four (4) days of admission.

XI.J.12. Team meetings of designated treatment and other staff, as needed by individual child/youth, must be held every three (3) days during the child/youth's stay to assess progress toward objectives on the Individualized Individual Service Plan and to make any revisions necessary to continue effective treatment. Attempts must be made and documented as part of Individual Service Plan development/revision to include the presence and/or input of parent(s)/legal guardian(s) and child/youth (as developmentally appropriate) at team meetings.

XI.J.13. The child's/youth's stay in the Crisis Residential Treatment Program must not extend beyond a maximum of twenty-one (21) consecutive days. An extension of this timeframe should be submitted in writing to the Director, Bureau of Community Services for approval by the DMH Review Committee.

XI.J.14. If a child/youth is readmitted to the Crisis Residential Treatment Program at any time after a previous discharge from the program, they must be evaluated for and again meet eligibility criteria specified in Standard XI.J.9.

Chemical Dependency Unit Services – Substance Abuse Prevention and Rehabilitation

XI.J.15. Chemical Dependency Unit Services include inpatient or hospital-based services for individuals with more severe alcohol and/or drug abuse problems and who require a medically-based environment. Treatment usually includes detoxification, group, individual, and family therapy, education services explaining alcohol/drug dependency, personal growth, and the recovery process, aftercare, and family counseling.

XI.J.16. The expected outcome for Chemical Dependency Unit Services is for all individuals in CDU Services to receive all needed components of the service.

XI.J.17. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of Alcohol and Drug Abuse for approval by the DMH Review Committee.

XI.J.18. Programs serving children or youth must also comply with the following Operational Standards Part XI, Section C and Standards XI.I.7 through XI.I.15.

XI.J.19. The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling with each individual;

c. Family counseling;
d. At least ten (10) hours per week of education services dealing with substance abuse and addiction, self-help/personal growth, social skills, anger management, and recovery process, and a philosophy of living which will support recovery;
e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational counseling and planning/referral for follow-up vocational services.

g. For children and youth, the academic schedule indicating school hours.

Primary Residential Services – Substance Abuse Prevention and Rehabilitation

XI.J.20. The Primary Residential Substance Abuse Treatment Program is an intensive residential program for individuals who are addicted to or abuse alcohol/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. Because alcohol and drug dependency is 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.

XI.J.21. Expected outcomes for Primary Residential Services include:

a. Individuals entering Primary Residential Services will complete the program within thirty (30) days and maintain a dependency free lifestyle.
b. An eighty-five percent (85%) utilization rate is expected.

XI.J.22. Programs serving children or youth must also comply with the following Operational Standards Part XI, Section C and Standards XI.I.7 through XI.I.15**.**

XI.J.23. Primary Residential Treatment programs serving pregnant and parenting women/legal guardians with young children who reside on the program site must also provide for adequate, secure, and supervised play space for the children of women served in the program.

XI.J.24. Programs must have accessibility either through program staff or affiliation agreement/contract to the following:

a. A licensed psychiatrist with experience in the treatment of substance abuse/addiction; or,

b. A licensed psychologist with experience in the treatment of substance abuse/addiction; and

c. A licensed physician with experience in the treatment of substance abuse/addiction.

XI.J.25. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of Alcohol and Drug Abuse for approval by the DMH Review Committee.

XI.J.26. The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling with each individual;

c. Family counseling;

d. 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;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational counseling and planning/referral for follow-up vocational services.

g. For child/youth, the academic schedule indicating school hours.

XI.J.27. Primary Residential programs serving pregnant and parenting women/legal guardians with young children who reside on the program site must adhere to the following:

a. Adequate, secure, and supervised play space for the children of women served in the program must be provided.

b. 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.

Crisis Stabilization Units (CSU) – Adult Mental Health

XI.J.28. CSU services are time-limited residential treatment service designed to serve adults with severe mental health episodes that if not addressed would likely result in the need for inpatient care. The community-based service setting provides intensive mental health assessment and treatment. Follow-up outreach and aftercare services are provided as an adjunct to this service.

XI.J.29. Expected outcomes for Crisis Stabilization Units include:

a. Individuals will be diverted from further treatment at a state psychiatric facility.
b. Individuals will remain in their community settings in order to receive services and supports in order to stabilize their symptoms of mental illness.
c. Decrease number of admissions to state psychiatric facilities.

XI.J.30. The program must maintain one staff member to each four (4) or fewer residents twenty-four (24) hours a day, seven (7) days a week. Each program must post in an area accessible to the public a staffing pattern approved by the DMH (signed by the Director, Bureau of Community Services) to include qualifications for each position and the number of positions per shift for each day of the week. Nursing services must be provided during all shifts.

XI.J.31. All providers of CSU services must develop policies and procedures which, at a minimum, address the following:

a. Twenty-four-hour-a-day, seven-days-a-week basis emergency admissions;

b. Safety and well-being of individuals who are experiencing a crisis, including procedures for the following:

(1) Notification of the program's attending physician;
(2) Implementation of programs and staff training for addressing potentially dangerous behaviors (such as aggression, suicide, etc.); and
(3) Observation of individual experiencing a crisis;

XI.J.32. Each program must have the following services available as needed by the resident;

a. Evaluation;
b. Observation;
c. Crisis counseling;
d. Alcohol and drug counseling;
e. Case management; and
f. Therapeutic activities, including recreational, educational, and social/ interpersonal, the intent of which is to involve the individual in reality-oriented events, must be available at least three (3) hours per day. Participation should be documented in the individual's record.

XI.J.33. Individuals must be involved, to the greatest extent possible, in the operation and decision-making process of the program.

a. Individuals must be involved, at incremental levels depending on capability, in the operation of the program. This involvement may include such things as

formulation and monitoring of CSU rules, as well as the daily operation of the program, e.g., cooking, cleaning, menu planning, activity planning, etc.;

b. Individuals must have meaningful involvement in the evaluation of the program, which must include, at a minimum and as appropriate, family and consumer satisfaction surveys.

XI.J.34. The DMH only allows seclusion to be used in a CSU.

XI.J.35. If a program uses a room for seclusion(s), the program must obtain written approval of the use of such room from the Director, Bureau of Community Services prior to its use for seclusion. To be approved for use for seclusion by the DMH, a room must meet the following minimum specifications:

a. Be constructed and located to allow visual and auditory supervision of the individual;

b. The dimensions of the room must be at least forty-eight (48) square feet; and

c. Be suicide resistant and have break resistant glass (if any is utilized in the room or door to the room).

XI.J.36. 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:

a. Clear definition(s) of seclusion and the appropriate conditions and documentation associated with its use. Seclusion is defined as behavioral control technique involving locked isolation. Such term does not include a time-out.

b. Requirements 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;

c. Requirements 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;

d. Requirements 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, and that such orders must be documented in the case record. The following requirements must be addressed in the policies and procedures regarding the use of seclusion and implementation (as applicable) documented in the individual case record:

(1) Orders for the use of seclusion must never be written as a standing order or on an as needed basis (that is, PRN);
(2) The treating physician must be consulted as soon as possible, if the seclusion is not ordered by the individual's treating physician;
(3) A physician or other licensed independent practitioner must see and evaluate the need for seclusion within one hour after the initiation of seclusion;
(4) 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;

(5) Seclusion must be in accordance with a written modification to the Individual Service Plan of the individual being served;
(6) Seclusion must be implemented in the least restrictive manner possible;
(7) Seclusion must be in accordance with safe, appropriate techniques; and,
(8) Seclusion must be ended at the earliest possible time.

e. Requirements that seclusion is not used as a form of punishment, coercion, or staff convenience;

f. Requirements that all staff who have direct contact with individuals being served must have ongoing education and training in the proper, safe use of seclusion;

g. 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; and,

h. Requirements that the original authorization order of the seclusion may only be renewed for up to a total of twenty-four (24) hours (in accordance with the limits of these standards) by a licensed physician or licensed independent practitioner, if less restrictive measures have failed.

XI.J.37. In addition to the following two standards regarding use of seclusion, providers of CSU must also meet all standards in Part V, Section A.

XI.J.38. Standard V.A.2(c) 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 maintained of the assessment in the individual's record.

PART XII

OUTPATIENT SERVICES

SECTION A- OUTPATIENT MENTAL HEALTH SERVICES

XII.A.1. Outpatient mental health services include **intake bio-psycho-social assessment**, and individual, group, and multi-family group therapies (excluding day treatment and case management) are the least intensive and most typically used interventions in the mental health field.

XII.A.2. Expected outcomes of outpatient mental health services include:

a. Individuals will achieve their individualized goals and objects identified on Individual Service Plans.
b. Individuals will experience a reduction in negative symptoms.

XII.A.3. Intake bio-psycho-social assessment is 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. The intake bio-psycho-social assessment must be completed by a mental health and/or intellectual/ developmental disabilities therapist.

XII.A.4. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and an individual receiving services.

XII.A.5. Family Therapy is defined as 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.

XII.A.6. Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2) but no more than eight (8) 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.

XII.A.7. Multi-Family Group Therapy is defined as psychotherapy that takes place between a mental health therapist and family members of at least two 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.

XII.A.8. The provider must have a written plan for services that identifies the manner in which each of the following special target populations will be served:

a. Elderly persons;

b. Individuals with serious mental illness;

c. Individuals with a dual diagnosis of mental illness and substance abuse;

d. Individuals with a dual diagnosis of mental retardation and mental illness;

e. Persons discharged from inpatient care;

f. Individuals with mental illness who are homeless.

XII.A.9. Outpatient services must be available and accessible at appropriate times and places to meet the needs of the population to be served. The program must establish a regular schedule, with a minimum of three (3) hours weekly for the provision of outpatient services during evenings and/or weekends.

XII.A.10. <u>For DMH/C providers of Outpatient Therapy Services for Children/Youth</u>
At a minimum, one outpatient therapist must be available at a school site in each public school district in the region served by the Community Mental Health Center (DMH/C).

XII.A.11. <u>For DMH/C providers of Outpatient Therapy Services for Children/Youth</u>
If the school district does not accept the provider's offer to provide outpatient therapy services, written documentation of non-acceptance (for the current school year) by the school district superintendent must be on file at the community mental health center for review by DMH personnel.

XII.A.12. <u>For DMH/C providers of Outpatient Therapy Services for Children/Youth</u>
The provider of outpatient services must have a written plan for services that identifies the manner in which each of the following special target populations of children/youth will be served:

a. Children/youth with a serious emotionally disturbance;

b. Children/youth with a dual diagnosis of serious emotional disturbance and substance abuse;

c. Children/youth with a dual diagnosis of serious emotional disturbance and mental retardation;

d. Children/youth transitioning from residential care (this includes psychiatric inpatient care, psychiatric residential treatment facilities, therapeutic group homes and therapeutic foster care).

e. Children/youth with serious emotional disturbance who are homeless;

f. Youth with serious emotional disturbance in transition from the children/youth services system to the adult service population.

XII.A.13. There must be written policies and procedures for:

a. Admission;

b. Coordination with case management and/or other services in which the individual is enrolled;

c. Follow-up designed to minimize dropouts and maximize treatment compliance;

d. Therapist assignments;

e. Referral to other appropriate services as needed; and

f. Discharge planning.

XII.A.14. The provider must have implemented policies and procedures that ensure that, at a minimum, for youth being discharged from inpatient care, residential treatment centers and therapeutic group homes:

a. The youth (and family member(s) as appropriate) are given an appointment with a mental health professional within two (2) weeks after referral;

b. The youth (and family member(s) as appropriate) are given an appointment with a physician within four (4) weeks after referral;

c. The youth (and family member(s) as appropriate) are evaluated for and/or enrolled in case management services within two (2) weeks after referral for community services;

d. Inpatient referral facilities have current contact office and phone number information so that aftercare appointments are made within the above required time frames; and,

e. Professional staff have been trained and are knowledgeable in the policies and procedures in a.-d. above.

XII.A.15. The provider must have implemented policies and procedures that ensure that, at a minimum, for individual(s) being discharged from inpatient care:

a. The individual is given an appointment with a mental health professional within two (2) weeks after referral;

b. The individual is given an appointment with a physician within four (4) weeks after referral;

c. The individual is evaluated for and/or enrolled in case management services within two (2) weeks after referral to community services;

d. Inpatient referral facilities have current contact office and phone number information so that aftercare appointments are made within the above required time frames; and,

e. Professional staff have been trained and are knowledgeable in the policies and procedures in a.-d. above.

XII.A.16. The program must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that:

a. Provide a phone number where contact can be made to arrange for an appointment;

b. Assure that only one call by the requesting person is needed to receive an appointment.

SECTION B- OUTPATIENT SUBSTANCE ABUSE AND REHABILITATION SERVICES

General Outpatient Substance Abuse and Rehabilitation Treatment Services

XII.B.1. General outpatient substance abuse treatment is appropriate for individuals in need of substance abuse services whose clinical condition or environment circumstances do not require a more intensive level of care. Providers of outpatient substance abuse treatment must provide the following services:

a. Individual therapy/counseling;

b. Group therapy/counseling; and

c. Family therapy/counseling.

XII.B.2. The expected outcome for General Outpatient Substance Abuse and Rehabilitation Services is for individuals to receive individual, group and/or family counseling to assist them in maintaining recovery and decrease need for more restrictive services.

Intensive Outpatient Program (IOP)

XII.B.3. The 10-Week Intensive Outpatient Program (IOP) is a community-based outpatient program which provides an alternative to traditional residential treatment or hospital settings. The program is directed to persons who need services more intensive than traditional outpatient services, but who have less severe alcohol and drug problems than those typically addressed in residential treatment. The IOP allows individuals to continue to fulfill his/her obligations to family, job, and community while obtaining intensive treatment.

XII.B.4. The expected outcome for the Intensive Outpatient Program is to allow individuals to receive intensive 10-12 weeks of treatment in their communities rather than in a restrictive residential or hospital setting.

XII.B.5. Intensive Outpatient Programs must provide the following services:

a. Group lecture or therapy for a minimum of three (3) nights a week for three (3) hours each night for at least ten (10) weeks;

b. Individual therapy at a minimum of one (1) counseling session, for a minimum of one hour, per week;

c. Involvement of family or significant others as necessary to meet needs of the individual.

PART XIII

ADULT MENTAL HEALTH SERVICES

All sections contained in this part pertain specifically to services and supports that are available to adults with serious mental illness.

SECTION A- PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT (PACT)

XIII.A.1. Assertive Community Treatment (ACT) 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.

XIII.A.2. Expected outcomes for PACT Services include:

a. Individuals receiving PACT Services will have decreased reliance on inpatient treatment.

b. Individuals who are hospitalized will have longer periods of time between hospitalizations.

c. Individuals receiving PACT services are satisfied with the services they receive that allow them to remain in the community while aiding in their recovery.

XIII.A.3. The important characteristics of assertive community treatment programs are:

a. ACT 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.

b. ACT services are delivered by a group of multidisciplinary mental health staff (as defined in Standard XIII.A.6) 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.

c. ACT 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.

d. 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.

e. ACT 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 recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery.

Staffing

XIII.A.4. 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 10 (10) individuals (this ratio does not include the psychiatrist or psychiatric nurse practitioner and the program assistant).

XIII.A.5. 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.

XIII.A.6. In addition to meeting the qualifications outlined in Part VI, the following positions are required for PACT Teams:

a. 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.

b. 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.

c. At least two (2) Full-time registered nurses. A team leader with a nursing degree cannot replace one of the FTE nurses.

d. At least one (1) Master's level or above mental health professionals (in addition to the team leader.)

e. At least one (1) Substance Abuse Specialist

f. At least one (1) Employment Specialist

g. At least one (1) FTE certified peer specialist. Peer specialists must be fully integrated team members.

h. 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 paraprofessional 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-services 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. 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.

XIII.A.7. 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 (not including the psychiatrist or psychiatric nurse practitioner and the program assistant).

XIII.A.8. 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.

Admission and Discharge Criteria

XIII.A.9 In order to be admitted into PACT services, individuals must meet the criteria outlined in Standards XIII.A.10 through XIII.A.12 below.

XIII.A.10 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.)

XIII.A.11. Individuals with significant functional impairments as demonstrated by at least one of the following conditions:

a. 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.

b. 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).

c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

XIII.A.12. 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):

a. High use of acute psychiatric hospitals (e.g., two or more admissions per

year) or psychiatric emergency services.

b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).

c. Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months).

d. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).

e. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or in imminent risk of becoming homeless.

f. 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.

g. Difficulty effectively utilizing traditional office-based outpatient services.

XIII.A.13. Discharges from the PACT team occur when individuals and program staff mutually agree to the termination of services. This must occur when individuals:

a. Have successfully reached individually established goals for discharge, and when the individual and program staff mutually agree to the termination of services.

b. 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.

c. 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.

d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable Individual Service Plan with the individual.

Frequency of Individual Contact

XIII.A.14. 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 times per day, seven 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.

XIII.A.15. 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.

XIII.A.16. The PACT team must provide a mean (i.e., average) of at least three (3) contacts per week for all individuals.

XIII.A.17. Each new PACT team must gradually build up its case load with a maximum admission rate of five (5) individuals per month.

Hours of Operation and Staff Coverage

XIII.A.18. The PACT team must be available to provide treatment, rehabilitation, and support activities seven days per week. When a team does not have sufficient staff numbers to operate two 8-hour shifts weekdays and one 8-hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on a individual-by-individual basis (per the individual-centered comprehensive assessment and individualized Individual Service Plan) in the evenings and on weekends. This includes:

a. Regularly scheduling staff to cover individual contacts in the evenings and on weekends.

b. Regularly scheduling mental health professionals for on-call duty to provide crisis and other services the hours when staff are not working.

c. 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.

d. 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).

e. If "c" or "d" occurs, memoranda of agreement or formal contracts should be established and kept on file by the provider.

Place of Treatment

XIII.A.19. Each PACT Team must set a goal of providing 85 percent of service contacts in the community in non-office-based or non-facility-based settings.

Staff Communication and Planning

XIII.A.20 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:

a. The PACT team must maintain a written daily log. The daily log provides:

(1) A roster of the individuals served in the program, and

(2) For each individual, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise,

behavioral description of the individual's status that day.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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.

XIII.A.21. 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:

a. Convene at regularly scheduled times per a written schedule set by the team leader.

b. 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.

c. Require individual staff members to present and systematically review and integrate individual information into a holistic analysis and prioritization of issues.

d. Occur with sufficient frequency and duration to make it possible for all staff:

(1) to be familiar with each individual and their goals and aspirations;
(2) to participate in the ongoing assessment and reformulation of issues/ problems;
(3) to problem-solve treatment strategies and rehabilitation options;
(4) to participate with the individual and the Individual Treatment Team in the development and the revision of the Individual Service Plan; and
(5) to fully understand the Individual Service Plan rationale in order to carry out each individual's plan.

Staff Supervision

XIII.A.22. 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:

a. 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;

b. 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;

c. Regular meetings with individual staff to review their work with individuals, assess clinical performance, and give feedback;

d. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, Individual Service Plans, Individual Service Plan reviews); and

e. Written documentation of all clinical supervision provided to PACT team staff.

Required Services

XIII.A.23. 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 (a-k):

a. Service Coordination/Individual Treatment Team

(1) 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.

(2) Each individual will be assigned to Individual Treatment Team (ITT.) The ITT is a group or combination of three (3) to five (5) ACT 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.

b. Crisis Assessment and Intervention

(1) 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 (see Part VIII, Section A) program as appropriate.
(2) A system must be in place that assures the individual can contact the PACT as necessary.

c. Symptom Assessment and Management

This must include but is not limited to the following:

(1) Ongoing comprehensive assessment of the individual's mental illness symptoms, accurate diagnosis, and the individual's response to treatment.

(2) Psycho-education regarding mental illness and the effects and side effects of prescribed medications.

(3) 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.

(4) Individual supportive therapy.

(5) Psychotherapy.

(6) 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.

d. Medication Prescription, Administration, Monitoring and Documentation

(1) The PACT team psychiatrist/psychiatric nurse practitioner must:

(a) Establish an individual clinical relationship with each individual.

(b) Assess each individual's mental illness symptoms and provide

verbal and written information about mental illness.

(c) Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist/psychiatric nurse practitioner will follow.

(d) Provide education about medication, benefits and risks, and obtain informed consent.

(e) Assess and document the individual's mental illness symptoms and

behavior in response to medication and must monitor and document medication side effects.

(f) Provide psychotherapy.

(2) 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.

(3) The PACT team program must establish medication policies and procedures which identify processes to:

(a) Record physician orders

(b) Order medication

(c) Arrange for all individual medications to be organized by the team and integrated into individuals' weekly schedules and daily staff assignment schedules

(d) 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

(e) Administer medications per state law to individuals receiving PACT services

(f) Comply with Part IV, Section J.

e. Dual Diagnosis Substance Abuse Services

(1) Dual Diagnosis 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:

(a) Engagement (e.g., empathy, reflective listening, avoiding argumentation).

(b) Assessment (e.g., stage of readiness to change, individual-determined problem identification).

(c) Motivational enhancement (e.g., developing discrepancies, psycho-education).

(d) Active treatment (e.g., cognitive skills training, community reinforcement).

(e) Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

f. Work-Related Services

(1) 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:

(a) 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.

(b) 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.

(c) Development of an ongoing employment plan to help each individual establish the skills necessary to find and maintain a job.

(d) Individual supportive therapy to assist individuals to identify and cope with mental illness symptoms that may interfere with their work performance.

(e) On-the-job or work-related crisis intervention.

(f) Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

g. Activities of Daily Living

(1) 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:

(a) 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).

(b) Perform household activities, including house cleaning, cooking, grocery shopping, and laundry.

(c) Carry out personal hygiene and grooming tasks, as needed.

(d) Develop or improve money-management skills.

(e) Use available transportation.

(f) Have and effectively use a personal physician and dentist.

h. Social/Interpersonal Relationship and Leisure-Time Skill Training

(1) 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:

(a) Improve communication skills, develop assertiveness, and increase self-esteem.

(b) Develop social skills, increase social experiences, and develop meaningful personal relationships.

(c) Plan appropriate and productive use of leisure time.

(d) Relate to landlords, neighbors, and others effectively.

(e) Familiarize themselves with available social and recreational

opportunities and increase their use of such opportunities.

i. Peer Support Services

(1) 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:

(a) Peer counseling and support.

(b) Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.

j. Support Services

(1) Support services or direct assistance to ensure that individuals obtain the basic necessities of daily life, including but not necessarily limited to:

(a) Medical and dental services.

(b) Safe, clean, affordable housing.

(c) Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance).

(d) Social services.

(e) Transportation.

(f) Legal advocacy and representation.

k. Education, Support, and Consultation to Individuals' Families and Other Major Supports

(1) Services provided regularly under this category to individuals' families and other major supports, with individual agreement or consent, include:

(a) Individualized psycho-education about the individual's illness and the role of the family and other significant people in the therapeutic process.

(b) Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people.

(c) Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family.

(d) Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

(e) Assistance to individuals with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

1. Services to help individuals throughout pregnancy and the birth of a child.

2. Services to help individuals fulfill parenting responsibilities and coordinate services for the child/children.

3. Services to help individuals restore relationships with children who are not in the individual's custody.

Stakeholder Advisory Groups

XIII.A.24. 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.

XIII.A.25. The stakeholder advisory group must:

a. Promote quality PACT model programs.

b. Monitor fidelity to the PACT program standards.

c. Guide and assist with the administering agency's oversight of the PACT program.

d. Problem-solve and advocate to reduce system barriers to PACT implementation.

e. Review and monitor individual and family grievances and complaints.

f. Promote and ensure individuals' empowerment and recovery values in assertive community treatment programs.

Program Requirements

XIII.A.26. 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.

SECTION B- CO-OCCURRING DISORDERS

XIII.B.1. Co-Occurring Disorders Services are provided to individuals who are affected by both a diagnosed mental illness and substance abuse disorder.

XIII.B.2. The expected outcome for Co-Occurring Services is that individuals with co-occurring disorders (mental illness and substance abuse) receive individualized services to meet their needs based on appropriate screening and assessment.

XIII.B.3. Providers must utilize the screening tool and assessment provided by the DMH.

SECTION C- DROP IN CENTER SERVICES

XIII.C.1. Drop In Center Services are a program 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.

XIII.C.2. The expected outcome for Drop In Center Services is that individuals will take control of their own recovery, focusing on building better lives.

XIII.C.3. Individuals receiving Drop in Center Services must meet eligibility requirements for one or more of the following service categories:

a. Adults who are determined to have a serious mental illness (SMI).

b. Individuals (adults) with a substance abuse diagnosis.

c. Chronically homeless

XIII.C.4. 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.

XIII.C.5. 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.

XIII.C.6. The program must have an annual average daily attendance of eight (8) individuals.

XIII.C.7. All program space must be accessible to both individuals and staff. There are to be no "staff-only" or "individual/member-only" spaces.

XIII.C.8. 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 by DMH.

XIII.C.9. Written policies and procedures, including a description of the program, must be maintained and must include, but not be limited to, the following:

a. The purpose, goals, and objectives of the program;

b. 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 a clubhouse or a work activity center, but still need structured daily activities;

c. The daily hours of operation and number of people to be served at each program site;

d. Description of the daily activities to be available;

e. Description of how to involve family members and significant others in supporting program participants;

f. Description of how the drop in center interacts with the traditional mental health center/programs;

g. Mechanisms to be used to establish members as decision makers in the operation of the service;

h. Description of how to develop and maintain consumer volunteers and employ consumers of mental health services; and

i. Description of homeless outreach activities.

XIII.C.10. The structured activities of the program must be designed to:

a. Maintain individuals in an environment less restrictive than inpatient or therapeutic residential treatment;

b. Develop daily living, social and other therapeutic skills;

c. Promote personal growth and enhance the self-image and/or improve or maintain the individual's abilities and skills;

d. Provide assistance in maintaining and learning new skills that promote independence;

e. Develop interpersonal relationships that are safe and wanted by the individual to eliminate isolation;

f. Improve physical and emotional well being; and,

g. Promote empowerment and recovery.

XIII.C.11. The provider must have structured activities that include the following as appropriate for each individual:

a. Social skills training.
b. Group therapy.

c. Individual therapy.

d. Training on use of leisure time activities.

e. Coping skills training.

XIII.C.12. 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 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.

XIII.C.13. Staffing ratio must be at least one (1) staff member at all times for every twelve (12) individuals served by the program.

XIII.C.14. The designated program supervisor (see Standard VI.C.1(c)) 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.

XIII.C.15. Drop In Center programs must have a board or advisory council that it made up of fifty percent (50%) consumers of mental health services.

XIII.C.16. The program must maintain an evaluation system which addresses at a minimum:

a. Total number of members on roll;

b. Daily attendance;

c. Annual attendance by subgroups (age, sex, race); and

d. Reasons for leaving the program (i.e. recidivism vs. progression toward community integration).

SECTION D- INPATIENT REFERRAL SERVICES

XIII.D.1. All programs certified as DMH/C must provide access to inpatient services in the individual's locale when appropriate.

XIII.D.2. Expected outcomes for Inpatient Referral Services include:

a. Individuals will have an increased knowledge of inpatient treatment options.
b. Individuals will have decreased waiting times for inpatient services.

XIII.D.3. The provider must have written policies and procedures for referral to inpatient services in the community, should an individual require such services.

XIII.D.4. The provider must maintain a current written agreement with a licensed hospital(s) to provide/make available inpatient services, which, at a minimum, addresses:

a. Identification of the community mental health program's responsibility for the individual's care while the individual is in inpatient status;

b. Description of services that the hospitals will make available to individuals who are referred; and,

c. How hospital referral, admission and discharge processes are coordinated with emergency, pre-evaluation screening and civil commitment services, and aftercare services.

SECTION E- PRE-EVALUATION SCREENING AND CIVIL COMMITMENT EXAMINATION SERVICES

XIII.E.1. Pre-evaluation screening and civil commitment examination **are two events which** include screening, examinations, and 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.

XIII.E.2. Expected outcomes for pre-evaluation screening and civil commitment examination services include:

a. Individuals/families receive a determination on need for civil commitment and/or other available mental health services in a timely manner.
b. Individuals and families are treated with respect during the pre-evaluation screening process.

XIII.E.3. The provider program 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:

a. The system for conducting pre-evaluation screenings;

b. The system for conducting civil commitment examinations;

c. The system for handling court appearances;

d. The services that are offered for the family and/or significant others;

e. 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.

XIII.E.4. The pre-evaluation screening must be conducted by qualified staff of a regional community mental health center, and

a. Be performed by:

(1) A certified licensed psychologist or physician; or

(2) Persons with a Master's degree in a mental health or related field who have received training and certification in pre-evaluation screening by the DMH; or,

(3) Registered nurses who have received training and certification in pre-evaluation screening by the DMH.

(4) Additionally, staff who meet requirements (2) and (3) above, have completed and provide documentation of:

(a) at least six months of experience working with individuals with serious mental illness or serious emotional disturbance and;

(b) at least two behavioral observations of pre-evaluation screenings performed by qualified staff.

b. Be performed in accordance with Mississippi civil commitment statutes.

c. Be documented on such forms and provide such information required by the civil commitment law and/or the DMH.

XIII.E.5. If the civil commitment examination service is provided, the examination must:

a. Be performed by two 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.

b. Be documented on such forms, providing information required by law or the DMH. Minimum documentation must include information in the individual case record of the commitment examination results and the official disposition following the examination;

c. Include the evaluation of the individual's social and environmental support systems; and,

d. Include, when possible, the development of a treatment and follow-up plan for the individual and the family and/or significant others.

SECTION F – DESIGNATED MENTAL HEALTH HOLDING FACILITIES

XIII.F.1. Designated mental health holding facilities (hereafter referred to as "holding facility") house 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 which the county contracts. DMH will conduct yearly on-site visits to each holding facility to ensure they are in compliance with the standards below.

XIII.F.2. Expected outcomes for Designated Mental Health Holding Facilities include:

a. Individuals receive physician's services and medications (if needed) in a timely manner while awaiting transportation to a treatment facility.
b. Staff receive training in how to appropriate work with and protect individuals who have a mental illness.

Policies & Procedures

XIII.F.3. Each holding facility must have a manual that includes the written policies and procedures for operating and maintaining the facility housing 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.

XIII.F.4. The policies and procedures must:

a. 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.

b. 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.

c. 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.

d. Describe how the policies and procedures are made available to the public.

Personnel Policies

XIII.F.5. 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, including employment history and experience;

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

c. A copy of college transcripts, high school diploma, and/or appropriate documents to verify that educational requirements of the job description are met;

d. Documentation of an annual performance evaluation.

e. A written job description that shall include, at a minimum:

(1) Job title;

(2) Responsibilities of the job;

(3) Skills, knowledge, training/education and experience required for the job.

f. 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.

g. 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.

Training and Staff Development

XIII.F.6. Supervisory and direct service staff who work with individuals housed 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.

XIII.F.7. Documentation of training of individual staff must be included in individual training/personnel records and must include:

a. Date of training
b. Name(s) of staff participating;
c. Topic(s) addressed;
d. Name(s) of presenter(s) and qualifications;
e. Contact hours (actual time spent in training).

XIII.F.8. 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:

a. First aid and life safety, including handling of emergencies such as choking, seizures, etc.;

b. Preventing, recognizing and reporting abuse/neglect, including provisions of the Vulnerable Adults Act, and the Mississippi Child Abuse Law;

c. Handling of accidents and roadside emergencies (for programs transporting only);

d. De-escalation techniques & crisis intervention, including appropriate use of seclusion and restraint and applicable state and federal regulations pertaining to such rights of individuals being housed in the facility;

e. 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;

f. Fire safety and disaster preparedness to include:

(1) Use of alarm system
(2) Notification of authorities who would be needed/require contact in an emergency;
(3) Actions to be taken in case of fire/disaster, and;
(4) Use of fire extinguishers;

g. Cardiopulmonary Resuscitation (CPR) training (every two years);

h. Recognizing and reporting serious incidents, including completion and submission of reports;

i. Universal precautions for containing the spread of contaminants;

j. Adverse medication reaction and medial response; and

k. Suicide precautions

Procedures for Admitting and Housing Individuals

XIII.F.9. Each facility shall have written procedures for admission of individuals who are being involuntarily civilly committed and awaiting transportation. These procedures shall include, but not be limited to, the following:

a. Determine that the individual is legally admitted for holding;
b. Make a complete search of the individual and his/her possessions;
c. Properly inventory and store individual's personal property;
d. Require any necessary personal hygiene activities (e.g., shower or hair care, if needed);
e. Issue clean, laundered clothing or appropriate garments (e.g., suicide risk reduction garments);
f. Issue allowable personal hygiene articles;
g. Perform health/medical screening;
h. Record basic personal data and information to be used for mail and visiting lists;
i. Provide a verbal orientation of the individual to the facility and daily routines.

Environment/Safety

XIII.F.10. If the designated mental health holding facility for civil commitment purposes is part of a correctional facility or jail, individuals awaiting transfer related to civil commitment proceedings (or just individuals detained as part of the civil commitment process) must be housed separately from pre-trial criminal offense detainees or inmates serving sentences.

XIII.F.11. Rooms used for housing individuals must be free from structures and/or fixtures that could be used by detainees to harm themselves.

XIII.F.12. 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.

Risk Assessment

XIII.F.13. The following to be conducted immediately upon arrival:

a. Suicide assessment (using a DMH approved screening instrument)
b. Violence risk assessment (using a DMH approved screening instrument)

XIII.F.14. 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.

XIII.F.15. If the risk level for suicide is deemed "high," immediate suicide prevention actions must be instituted.

Assessment and Clinical Management

XIII.F.16. Each holding facility shall have written procedures 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:

a. 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.
b. 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:

(1) Vital signs (at a minimum: body temperature, pulse/heart rate, respiratory rate, & blood pressure)
(2) Accu-Chek monitoring for persons with diabetes
(3) Medical/drug history
(4) Allergy history
(5) Psychiatric history (note: look at pre-evaluation form)

XIII.F.17. Clinical Management of the individual being held should include:

a. Within seventy-two (72) hours of admission, individuals should be assessed by a psychiatrist or a psychiatric nurse practitioner.

b. Twenty-four (24) hour crisis/on-call coverage by a physician or psychiatric nurse practitioner.

c. Availability of ordered pharmacologic agents within twenty-four (24) hours.

d. Timely administration of prescribed medication in accordance with the MS Nurse Practice Act.

e. Access to medical services for preexisting conditions that require ongoing medical attention (e.g. high blood pressure, diabetes, etc.)

f. 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 detoxification).

g. Availability of continuous assessment or monitoring for persons with mental illness or substance abuse considered by medical or psychiatric staff to be at high risk.

h. Training/certification of staff in prevention/management of aggressive behavior program.

i. Procedures for maintenance of clinical records, including:

(1) Documentation of information by professional staff across disciplines,
(2) Documentation of physician's orders
(3) Basic personal data and information that ensures rapid emergency contact, if needed.

Dignity of Individuals

XIII.F.18. 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:

a. Protection and advocacy services/information
(1) Disability Rights MS 601-968-0600
(2) Dept. of Mental Health 877-357-0388
b. Chaplain services
c. Telephone contact
d. Visits with family members

SECTION G- CONSULTATION AND EDUCATION SERVICES

XIII.G.1. Consultation and education services utilize staff skills and knowledge to promote, develop, and/or strengthen mental health service delivery in the area served.

XIII.G.2. Expected outcomes for Consultation and Education Services include:

a. Increased community awareness of mental health related issues.
b. Linkages are developed with schools, community groups and other social/human services agencies.

XIII.G.3. The provider of the consultation and education program must develop and implement a written plan to provide for consultation and education services. The plan must include a range of activities for:

a. Developing and coordinating effective mental health education, consultation, and public information programs;

b. Increasing the community awareness of mental health related issues.

XIII.G.4. The consultation and education service must be designed to specifically meet the needs of the target populations of:

a. Children and youth;

b. Elderly persons;

c. Individuals with serious mental illness;

d. Individuals with intellectual/developmental disabilities;

e. Individuals with a dual diagnosis (MH/A&D);

f. Individuals with a mental illness who are homeless;

g. Military families and the military community;

h. Other populations defined by the center/program.

XIII.G.5. The program must develop linkages with other health and social agencies that serve the target populations.

PART XIV

ALZHEIMER'S AND OTHER DEMENTIA SERVICES

XIV.A. Standards in this section apply to Adult Day Services for persons with Alzheimer's disease and other dementia. These programs must also comply with applicable standards under Part I through Part VII of the DMH Operational Standards.

XIV.A.1. The key elements of Adult Day Services are an interdisciplinary approach to meeting goals for individuals served in the program and the variety of services offered by the program to meet individuals' needs. Adult Day 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, optimizing the health of the individuals. Adult Day Services provide a structured environment for individuals with Alzheimer's disease and related dementia; counseling for family members and/or other care givers; and education and training for individuals providing services to those with Alzheimer's disease and related dementia and also to family members and/or care givers; and respite. By supporting families and caregivers, adult day centers enable individuals with Alzheimer's disease and other dementia to live in the community.

XIV.A.2. Adult Day Services 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. Adult Day Services assess the strengths and needs of individuals and families and offer services to build on their strengths

XIV.A.3. The expected outcome for Adult Day Services is that individuals with Alzheimer's disease and other dementia and their family members/caregivers are supported in their communities.

XIV.A.4. Adult Day Centers provide services for adults with physical and psychosocial impairments, who require supervision, including:

a. Persons who have few or inadequate support systems.

b. Persons who require assistance with activities of daily living (ADLs).

c. Persons with memory loss and other cognitive impairment(s) resulting from Alzheimer's and other dementia that interfere with daily functioning.

d. Persons who require assistance in overcoming the isolation associated with functional limitations or disabilities.

e. Persons whose families and/care givers need respite.

f. Persons who, without intervention, are at risk of premature long-term placement outside the home because of memory loss and/or other cognitive impairment(s).

XIV.A.5. The programs providing Adult Day Services must meet the following minimum staffing requirements:

a. A full-time Program Supervisor (see Standard VI.C.1(c)) with (1) at least one year of supervisory experience in a mental health, social or health service setting or (2) comparable technical and human services training, with demonstrated competence and experience as a manager in a human services setting;

b. A full-time Activities Coordinator, who can also serve as Assistant Program Supervisor, with a minimum of a 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;

c. A full-time Program Assistant with a minimum of an Associate's degree and at least one (1) year of experience in working with adults in a health care or social service setting;

d. 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;

e. Secretary/Bookkeeper with a minimum of a high school diploma or equivalent and skills and training to carry out the duties of the position;

f. 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.

XIV.A.6. 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.

Therapeutic Activities

XIV.A.7. The adult day services program for Alzheimer's Disease and other dementia 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:

a. Personal interaction;

b. Individualized activities;

c. Small and large group activities;

d. Intergenerational experiences;

e. Outdoor activities, as appropriate;

f. Self-care activities;

g. Culturally and ethnically relevant celebrations

XIV.A.8. 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.

XIV.A.9. Individuals must be allowed time for rest and relaxation and to attend to personal and health care needs.

XIV.A.10. 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.

XIV.A.11. Creative arts activities must be provided to improve or maintain physical, cognitive, and/or social functioning of individuals served by the program.

Education and Training

XIV.A.12. 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 should be kept by the Program Supervisor

XIV.A.13. As an opportunity for ongoing training, 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 should be made on a monthly basis or more frequently if determined necessary by the Program Supervisor.

Assistance with Activities of Daily Living

XIV.A.14. 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.

Food Services

XIV.A.15. 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.

XIV.A.16 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.

Facility

XIV.A.17. Each adult day service center, when it is co-located in a facility housing other services, must have its own separate, identifiable space for all activities conducted during operational hours.

XIV.A.18. The adult day service center facility must provide at least sixty (60) square feet of program space for multipurpose use for individuals served in the program. A single program may serve no more than twenty-five (25) individuals at a time.

XIV.A.19. 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.

XIV.A.20. The facility must have an identified separate space available for individuals and/or family/caregivers to have private discussions with staff.

XIV.A.21. The facility's restrooms must be located as near the activity area(s) as possible

XIV.A.22. The facility must have a rest area for individuals served in the program and must have a minimum of one (1) reclining chair per four (4) individuals served in the program.

XIV.A.23. The facility must utilize an operable electronic security system that has the capacity to monitor unauthorized entrance or egress, or other movement through the entrance/exits.

XIV.A.24. Outside space that is used for outdoor activities must be safe, accessible to indoor areas, and accessible to individuals with disability(ies).

XIV.A.25. The program must have secure, exterior pathway(s), a minimum of four (4) feet in width.

XIV.A.26. Adequate outside seating must be provided.

XIV.A.27. 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.

PART XV

CHILDREN/YOUTH MENTAL HEALTH SERVICES

All sections contained in this part pertain specifically to services and supports that are available to children/youth with serious emotional disturbance.

SECTION A- PREVENTION/EARLY INTERVENTION SERVICES

XV.A.1. 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 may be designed to target a specific group of children and/or their families, such as children who have been abused or neglected, teenage parents and their children, and young children and their parents. Children 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.

XV.A.2. Expected outcomes for Prevention/Early Intervention Services include:

a. Children and their families will have none or decreased involvement with the court system.
b. Children/youth with SED will have an increase in the stability of family and home placements.
c. At-risk children will receive crisis response that is timely and appropriate.

XV.A.3. A staff member must be designated to plan, coordinate and evaluate the prevention/early intervention program.

XV.A.4. All prevention/early intervention programs must maintain documentation that services include, but are not limited to, the following:

a. Utilization of a range of strategies, such as:

(1) Information activities designed to provide accurate and current information about emotional disturbance and mental illness in children and adolescents; or
(2) Affective 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.

XV.A.5. Prevention programs must maintain records documenting utilization of strategies as described in Standard XV.A.4.

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 in accordance with the Part IV, Section H and 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.

SECTION B- FAMILY SUPPORT AND EDUCATION SERVICES

XV.B.1. Family Support and Education Services, which provide self-help and mutual support for families of youth with mental illness or emotional disturbances, are based on the view that individuals with similar circumstances have the capacity to understand and assist each other, and that the support of other concerned individuals is a great asset in helping to cope with difficulties.

XV.B.2. Expected outcomes for Family Support and Education Services include:

a. Families of children/youth with serious emotional disturbance(s) will be better able to access services.
b. Families of children/youth with serious emotional disturbance(s) will obtain support and develop coping mechanisms needed to deal with their child's/ youth's disorder.

XV.B.3. 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.

XV.B.4. 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:

a. Description of individuals targeted to receive family support and education services;

b. Specific strategies to be used for outreach to the target population for family support and education services;

c. Description of qualifications and specialized training required for family support and education providers;

d. Description of service components of the family support and education program.

XV.B.5. 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 or types of presentations with an individual family or groups of families. At a minimum, these activities must address <u>one or more</u> of the following or other DMH pre-approved topics:

a. Identified methods and approaches commonly used to identify children/youth with behavioral, conduct or emotional disorders;

b. Development of a family action plan;

c. Prevalent treatment modalities;

d. Common medications;

e. Child development;

f. Problem-solving;

g. Effective communication;

h. Identifying and utilizing community resources;

i. Parent/professional collaboration;

j. Overview of a collaborative service network;

k. Consultation and education; and,

l. Pre-evaluation screening for civil commitment for ages fourteen (14) and up.

SECTION C- MAP TEAMS

XV.C.1. MAP Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders, including, but not limited to, conduct disorders, or mental illness, who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

XV.C.2. Expected outcomes for MAP Teams include:

a. Children/youth will be served and remain in their homes and communities.
b. Families will be referred to community resources provided by multiple local agencies and entities.
c. Children/youth will be prevented from utilizing placements to Psychiatric Residential Treatment Facilities (PRTF) in order to access needed services and supports.
d. Children/youth will be successfully transitioned back into their homes and communities from inpatient care.

XV.C.3. All providers certified as community mental health centers (DMH-C) must make available or participate in at least two (2) Making a Plan (MAP) Teams in each community mental health region.

XV.C.4. Each MAP Team must be comprised of, at least, one child behavioral health representative employed by the Regional CMHC with a Bachelor's degree. In addition, there must be at least one representative from each of the following:

a. Each local school district in a county served by a MAP Team;

b. County Family and Children's Services Division of the State Department of Human Services;

c. County or Regional Youth Services Division of the State Department of Human Services; and,

d. County or Regional Office of the State Department of Rehabilitation Services.

e. County or Regional Office of the Mississippi State Department of Health; and,

f. Parent or family member with a child who has experienced an emotional and/or behavioral disturbance**.**

g. 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.

XV.C.5. The community mental health center (DMH-C) must maintain a current written interagency agreement with agencies participating in the MAP Team.

XV.C.6. A CMHC Master's level therapist must participate in the regional A Team Meetings that are held within their catchment areas. *(Please refer to the DMH Division of* ***Children and Youth Services Directory for definition and locations of A-Teams.)***

SECTION D- FETAL ALCOHOL SPECTRUM DISORDERS (FASD) SCREENING, DIAGNOSIS AND TREATMENT SERVICES

XV.D.1. 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. FASD occurs in about 1% of all live births, or about 450 to 500 new cases in Mississippi per year. FASD now outranks Down syndrome and autism in prevalence. The Institute of Medicine reported to Congress that "Of all the substances of abuse (including cocaine, heroin, and

marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus." The damage caused by prenatal alcohol exposure is permanent. The effects cannot be reversed, but many of them can be treated with the appropriate combination of interventions and support. Secondary disabilities of FASD include mental health issues (90%), school problems (60%), trouble with the law (60%) and attempted suicide (23%). 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.

XV.D.2. Expected outcomes for FASD Screening, Diagnosis and Treatment Services include:

a. Children with a FASD will experience a reduction in the occurrence and impact of the secondary disabilities associated with a FASD.

XV.D.3. 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 FASD if there is indication of prenatal alcohol exposure.

XV.D.4. The FASD screening tool will be provided to entities certified under the DMH/C option by the Division of Children and Youth Services (see the DMH Record Guide). The screening may be conducted by a case manager, a therapist, or other children's mental health professional.

XV.D.5. 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.

XV.D.6. Results of the FASD screening and FASD diagnostic evaluations, if indicated, must be reflected in the child's Individual Service Plan and/or case management service plan. If a child receives a fetal alcohol-related diagnosis, it should be recorded on the appropriate Axis.

XV.D.7. If a child's initial FASD screening result is negative, the screening process must be repeated at the annual case review to determine if additional information regarding maternal alcohol history has been obtained that might change the results of the initial FASD screen.

XV.D.8. With consent obtained from the parent/legal guardian, children 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. With consent obtained from the parent/legal guardian, a CMHC staff person must accompany the child and parent/guardian to the diagnostic appointment in order to participate in the child's history interview and the informational interview.

XV.D.9. Treatments and interventions recommended by the FASD multi-disciplinary diagnostic team must be either provided or facilitated by the CMHC mental health professional, as applicable to the identified scope of practice for the mental health professional. Referral to the local MAP Team should be made when appropriate.

XV.D.10. Because children with an FASD often do not respond to traditional mental health services and/or treatments, children's mental health services may need to be modified in order to be more effective for children with an FASD.

XV.D.11. 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.

SECTION E- RESPITE CARE SERVICES

XV.E.1. Respite care is a planned break for parents who are caring for a child/youth with emotional/behavioral problems. Respite care can be used by biological, adoptive, and foster parents and can occur as frequently as weekly. Trained respite parents or counselors assume the duties of care-giving and supervising youth for a brief period of time in order to allow the parents a break from the constant strain of parenting a child with serious emotional problems.

XV.E.2. Expected outcomes for Respite Care Services include:

a. Children/youth have increased access to care which minimizes crisis situations.
b. Children/youth and their families receive Respite Services are individualized and tailored to meet the needs of children/youth and their families.

XV.E.3. 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.

XV.E.4. In addition to the requirements in Part II, 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;

c. Description of procedures for determining the need for and development, implementation and supervision of behavior change/management programs for children/youth served on a regular basis.

XV.E.5. Providers of respite services must maintain documentation of linkages with other health and social service agencies, particularly those that serve children/youth.

XV.E.6. 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.

XV.E.7. 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 guardian(s) and youth being served in the program, as part of information provided to youth, parent(s)/legal guardian(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. Rights of individuals served in the program (as specified in Part V, Rights of Individuals Receiving Services), including the name of the person or office the parent(s) or guardian(s) may contact if they feel their child's rights have been violated.

XV.E.8. 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 VI, Section D -

Training and Staff Development and Part V, Rights of Individuals Receiving Services.

PART XVI

PEER SUPPORT SERVICES

XVI.PS.1. 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.

XVI.PS.2. Expected outcomes of Peer Support Services include:

a. Individuals have decreased hospital admissions.
b. Individuals have improved social functioning.
c. Individuals have improved ability to cope with/accept illness.
d. Individuals have improved outreach to the seriously mentally ill population.
e. Individuals have improved efficiency of intensive case management services.
f. Individuals have reduced crisis events.
g. Individuals have improved relationships with family members.
h. Individuals have improved quality of life.
i. Individuals have increased employment opportunities and/or stability.

XVI.PS.3. Providers of Peer Support Services must develop and implement a service provision plan that addresses the following:

a. The population to be served, including the expected number of individuals to be served, diagnoses, age and any specialization.

b. The types of services and activities offered, particular peer supports utilized, including whether services will be proved on an individual or group basis, type of intervention(s) practiced, typical program day or service and expected outcomes.

c. 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.

d. A description of how the mental health professional will maintain clinical

oversight of Peer Support Services, which includes ensuring that services and supervision are provided consistently with DMH requirements.

e. 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.

f. 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.

XVI.PS.4. Peer support services are voluntary. Individuals and/or their guardians must be offered this service when indicated as necessary to promote recovery by a mental health professional and/or physician.

XVI.PS.5. Peer Support Services are provided one on one or in groups. When rendered in groups, the ratio of staff to individuals receiving the service should be, at a minimum, one staff member to eight (8) individuals.

XVI.PS.6. Peer Support Services must be included in 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.

XVI.PS.7. Peer Support Services may be provided in conjunction with other Medicaid-reimbursable services, including Case Management Services. However, not more than one service can be provided to the same individual during the same time period**.**

XVI.PS.8. Certified Peer Support Services are separate and distinct services that must be documented separately in order to be eligible for reimbursement from Medicaid. For some services such as PACT, Peer Specialists are integrated into the team and are not eligible for reimbursement.

XVI.PS.9. Peer Support Services must be supervised by a mental health professional who has completed the DMH required peer supervisory training.

XVI.PS.10. 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.

XVI.PS.11. 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.

PART XVII

INTELLECTUAL/DEVELOPMENTAL DISABILITIES SERVICES

All sections contained in this part pertain specifically to services and supports that are available to individuals with intellectual/developmental disabilities.

SECTION A- EARLY INTERVENTION SERVICES

XVII.A.1. 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.

XVII.A.2. Expected outcomes for Early Intervention Services include:

a. Children will experience a reduction in risk factors associated with developmental delays.
b. Families are linked to community resources.

XVII.A.3. All Early Intervention Programs and Child Development Programs must adhere to the following standards:

a. 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.

b. 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.

c. Families of children under three years of age must be informed of the First Steps Early Intervention Program (FSEIP) unless referred from FSEIP.

d. 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 years.

e. Program staff must participate in review, revisions, and annual updates of each child's Individual Family Service Plan (ISFP).

f. 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.

g. 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.

h. 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.

(3) Participate in IFSP meetings to discuss transition activities as requested through written prior notice form from First Steps.

XVII.A.4. First Steps Early Intervention Programs (FSEIP) must adhere to the following.

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 primary service provider (specified on page 6 of IFSP) must complete outcomes rating for child within sixty (60) days prior to exit of the program. If the program is a service provider (other than primary), updated assessment and other information must be given to the primary service provider with in sixty (60) days prior to exit of the program.

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.

XVII.A.5. Child Development Services must adhere to the following:

a. Within thirty (30) days of admission and at least annually thereafter, 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. The program must 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. When OT, PT and/or SLP services are provided, the following must be documented and maintained in the child's record:

(1) Training provided by the specialist(s) for program staff.

(2) Any special techniques needed for the safe handling of a child; and

(3) How program staff might implement any recommended special procedures/techniques into the child's educational program.

d. The program must document progress toward meeting goals and objectives as required in the DMH Record Guide.

e. 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.

f. 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.

SECTION B – DAY SERVICES – ADULT

(referred to as Day Habilitation in 2002 Revision of DMH Standards)

XVII.B.1. ID/DD Waiver day services for adults are designed to foster greater independence, personal choice, and improvement/retention of self-help, socialization, positive behavior, and adaptive skills. Services are provided in a community-based setting. A central component of the service is to provide opportunities for individuals to become more independent, productive, and integrated in their community.

XVII.B.2. Expected outcomes for Day Services – Adult include the following:

a. Individuals are engaged in person-centered planning.
b. Individuals are engaged in meaningful activities and community integration opportunities.

XVII.B.3. Day services for adults must include the following services/activities:

a. Administration of a functional skills assessment using instrument(s) specified by BIDD;

b. Development of a service plan based on information from the functional skills assessment as well as other information provided by the individual/legal representative to ensure his/her choices/desired outcomes are addressed;

c. Transportation to and from an individual's residence and as necessary to participate in chosen activities away from the certified day services for adults program.

d. Personal care which includes providing direct supports and/or supervision/assistance in the areas of personal hygiene, eating, communication, mobility, toileting, and/or dressing to increase the individual's ability to participate in the community;

e. Daily opportunities for varied activities, both passive and active;

f. Opportunities to make choices about the activities in which he/she participates;

g. Implementation of positive behavior support plans when appropriately trained by a behavior support/interventionist.

h. Assistance in using communication and mobility devices when indicated in the individualized assessment and service plan.

XVII.B.4. Day Services for adults may take place in the community and/or in a DMH certified site. Additionally:

a. Certified facilities must be open at least five (5) days per week, six (6) hours per day;

b. A minimum of fifty (50) square feet of usable space must be available per each individual in the program. Additional square footage may be required for individuals who use wheelchairs.

c. Planned activities must be available during normal program hours;

d. Community integration opportunities must be offered at least weekly and address at least one of the following:

(1) Activities which address daily living skills/needs; or

(2) Activities which address leisure/social/other community events.

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e. All community integration activities must be based on choices/requests of the individuals served and documentation addressing the choices

offered and the chosen activities must be maintained in each person's record.

XVII.B.5. 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.

XVII.B.6. When providing opportunities for community inclusion, there must be at least one (1) staff person for every four (4) people, if none of the four (4) requires mobility assistance. If anyone in a group of four (4) requires mobility assistance, there must be at least two (2) staff for the group of four (4) people. Depending on individual requirements for support, additional staff may be required.

XVII.B.7. A person cannot be excluded from participating in community activities because he/she requires one-on-one assistance.

XVII.B.8. Equipment and materials in the program must be appropriate for adults. There must be an adequate supply of materials to ensure each person is able to engage/participate in a chosen activity at any time.

XVII.B.9. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to address activities contained in their service plan as well as other equipment which might be necessary to allow the individual to successfully participate in chosen activities.

XVII.B.10. The program is responsible for ensuring each individual receives a minimum of one midmorning snack, one nutritious noon meal, and one mid-afternoon snack. Individuals must be offered choices about what they eat and drink.

SECTION C- PRE-VOCATIONAL SERVICES

XVII.C.1. Prevocational services are provided to persons not expected to be able to join the general workforce within one year (excluding supported employment programs). Activities are not primarily directed at teaching specific job skills, but at underlying skills which are useful in obtaining community employment. Prevocational services are available to individuals who are no longer eligible for educational services based on their graduation and/or receipt of diploma/equivalency certificate and/or their permanent discontinuation of educational services within the parameters established by the Mississippi Department of Education.

XVII.C.2. The expected outcome for Pre-Vocational Services is that individuals will develop the skills necessary to obtain and maintain community employment.

XVII.C.3. Prevocational services must be provided in a certified work activity center that meets all the requirements of the U.S. Department of Labor.

XVII.C.4. The provider must administer a functional skills assessment using instruments specified by BIDD.

XVII.C.5. The provider must develop a service plan, based on information from the functional skills assessment as well as information provided by the individual/legal representative, to ensure his/her choices/desired outcomes are addressed.

XVII.C.6. Based on the results of the individualized assessment and as indicated on the service plan, prevocational services must provide the following:

a. Transportation between the individual's place of residence and the site of the prevocational services, and/or on community outings/job exploration;

b. Instruction in basic safety principles according to his/her current activities in the program;

c. A realistic work atmosphere;

d. Encouragement and support of good work habits;

e. Teaching/demonstration of the proper care and handling of equipment, materials, tools, and machines;

f. Teaching/encouragement of appropriate responses to requests from supervisors and/or co-workers;

g. Addressing issues such as punctuality, safe work practices, following directions, attending to tasks, problem solving, social skills appropriate for the work place, and use of small appliances;

h. Personal care/assistance, but it may not comprise the entirety of the service; and

i. Opportunities for community integration and exposure to work experiences (job exploration) outside the center-based setting and which

must:

(1) Be offered to each individual at least one time per month and be documented in his/her record;

(2) Take place with a group of no more than four individuals at a time with at least one staff person, depending on each person's identified level of required support;

(3) Provide the level of staff necessary to ensure the health and welfare of the individuals; and

(4) Include individuals who may require one-on-one assistance.

XVII.C.7. If an individual begins earning more than fifty percent (50%) of the minimum wage, the individual, appropriate staff, and the ID/DD Waiver Support Coordinator must review the necessity and appropriateness of prevocational services.

XVII.C.8. The program must have a "Return to Prevocational Services" policy which ensures individuals who leave the program to work in the community can return to the program if their community job ends.

XVII.C.9. 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 (see Standard VI.C.1 (c)).

XVII.C.10. The program must be in operation a minimum of five (5) days a week, at least six (6) hours per day.

XVII.C.11. The program must ensure it will make available lunch and/or snacks for individuals who do not bring their own.

SECTION D- WORK ACTIVITY CENTER SERVICES

XVII.D.1. 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.)

XVII.D.2. Expected outcomes for Work Activity Center Services include:

a. Individuals increase their productivity.
b. Individuals increase their self-sufficiency.
c. Individuals increase their community inclusion activities.

XVII.D.3. 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.

XVII.D.4. Work Activity Services must include:

a. Work which is:

(1) Real, remunerative, productive, and satisfying for the individual served; and
(2) Planned and adequate to keep all individuals productively and appropriately occupied.

b. Non-work which:

(1) Is intended to increase and enhance activities which allow the individual to be more self sufficient and to increase community integration;

(2) Takes place when work is reduced and/or when the individual chooses.

XVII.D.5. The program must have adequate work to keep individuals productively occupied while at the work activity center.

a. If there is not adequate work to allow everyone to be productively occupied, the program must have documentation of how it is actively seeking a variety of work.

b. Programs found not to have adequate work will be placed on probation for a maximum of six (6) months.

(1) Programs on probation must submit monthly reports to BIDD (on required forms) detailing their activities and progress towards locating and obtaining adequate work.
(2) Programs which do not have sufficient documentation of how they have tried to locate and obtain adequate work may be decertified.

(3) Programs which have sufficient documentation of how they have tried to locate and obtain adequate work, yet have not been able to secure such work, may continue to operate at the discretion of the Director, BIDD.

XVII.D.6. The program must assure reasonable accommodations in assisting the individual in increasing his/her productivity. Expected accommodations must, as needed, include:

a. Modifying equipment, jigs, and fixtures;

b. Modifying the work site and commonly used surrounding areas;

c. Purchasing aids and devices to assist individuals with their work; and/or

d. Allowing flex time, part-time, or extended break time.

XVII.D.7. Wage payments must be monetary and not in-kind or barter. Records pertaining to individual wages must include, at a minimum, the following:

a. Individual's name;

b. Hours worked;

c. Task(s) performed;

d. Wages paid; and

e. Method of payment (cash, check, direct deposit.)

XVII.D.8. Each person must receive a written statement for each pay period which must include:

a. Gross pay;

b. Net pay;

c. Hours worked;

d. Deductions; and

e. The individual’s signature indicating he/she received a written statement. These signatures must be maintained in the individual’s record.

XVII.D.9. Pay periods cannot exceed thirty-one (31) calendar days.

XVII.D.10. 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.

XVII.D.11. Community wage rate information must be obtained annually and must include at a minimum the following:

a. Prevailing wage for the type or similar type of work being performed;

b. Dates community wage rate information was obtained; and

c. Source of the information.

XVII.D.12. The program must have a "Return to Work Activity Policy" which ensures individuals who leave the program to work in the community can return to the work activity center if their community job ends.

XVII.D.13. Work Activity Programs 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:

a. Individuals are informed of any aspects of program operations and plans which effect their wages or welfare;

b. Individuals are asked for suggestions for changes/improvements they would like to see; and

c. Individuals are afforded the opportunity to ask questions and receive answers.

XVII.D.14. 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.

XVII.D.15. Preventive measures must be utilized at all times to ensure the safety of the individuals and staff which include, at a minimum:

a. The safe use of equipment;

b. The use of protective clothing, shoes, and eyewear;

c. 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;

d. The storage and control of raw materials and finished products outside the work area;
e. The replacement of worn or frail electrical cords or machinery; and

f. The maintenance of the site and equipment in a safe manner.

SECTION E- SUPPORTED EMPLOYMENT SERVICES

XVII.E.1 Supported Employment is designed to increase the independence, community integration, and productivity of individuals by providing support services necessary to achieve and maintain competitive employment and/or self employment. Competitive employment is defined as having a job in a business(es) in the community where individuals without disabilities are employed. Additionally, supported employment may consist of services to support and/or assist an individual in starting his/her own business.

XVII.E.2. Expected outcomes for Supported Employment Services include:

a. Individuals achieve and maintain community employment.
b. Individuals increase their level of independence.
c. Individuals have increased opportunities for community integration.

XVII.E.3. Supported employment consists of three types of individualized services designed to assist/support an individual in obtaining and maintaining a job in the community. Providers must be able to provide all three aspects of supported employment.

a. Job development and placement;
b. Training/coaching to assist/support the individual in learning the job requirements and how to perform it; and
c. Varying levels/types of ongoing job support necessary for the individual to maintain the job.

XVII.E.4. Supported employment services:

a. Must provide transportation to conduct job finding activities and to transport the individual to and from his/her job;

b. Are provided in settings where individuals without disabilities are employed;

c. Are only available for individuals who are/will be compensated directly by the employer, 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 people without disabilities;

d. Can be provided in groups of no more than three (3) individuals and one (1) staff person;

e. Cannot be provided in prevocational or work activity programs;

f. Cannot be used to support volunteer work or unpaid internships; and

g. Include personal care/assistance when specified in the individual's supported employment service plan.

SECTION F- SUPPORT COORDINATION SERVICES

XVII.F.1. Support coordination services are provided to individuals enrolled in the ID/DD Waiver. Support coordination is designed to coordinate and monitor all services an individual receives, regardless of funding source, to ensure services are adequate, appropriate, and meet individual needs.

XVII.F.2. The expected outcome for Support Coordination Services is that participants in the ID/DD Waiver receive coordinated services to maximize resources in order for them to remain at home and in the community.

XVII.F.3. Support coordinators are responsible for performing the following activities and for maintaining documentation of such in the individual's record:

a. Developing/reviewing/revising each individual's approved plan of care;

b. Informing each individual about all qualified providers for the services on his/her approved plan of care;

c. Submitting all required information for review/approval/denial to the BIDD;

d. Notifying each individual of approval/denial for:

(1) Initial enrollment;

(2) Requests for additional services;
(3) Requests for increases in services;
(4) Requests for recertification of ICF/MR level of care;

e. Notifying each individual of:

(1) Reduction in service(s);
(2) Termination of service(s); and/or
(3) Discharge from the ID/DD Waiver program.

f. Informing and providing the individual/legal representative with the procedures for appealing the denial, reduction, or termination of ID/DD Waiver services, discharge from the ID/DD Waiver, or determination of ineligibility due to not meeting intermediate care facility for the mentally retarded (ICF/MR) level of care requirements.

g. Locating and gaining access to all services listed on the plan of care, regardless of funding source;

h. Ongoing monitoring and assessment of the individual's plan of care 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 if there is a need for any new services (ID/DD Waiver and others) based upon expressed needs or concerns or changing circumstances;
(4) Information addressing whether the amount/frequency of service(s) listed on the approved plan of care remains appropriate; and
(5) Review of service plans developed by agencies which provide ID/DD Waiver services to the individual.

i. Ensuring all services a person receives, regardless of funding source, are coordinated to maximize the benefit for the individual and to prevent duplication of services;

j. Performing all necessary functions for the individual's annual recertification of ICF/MR level of care;

k. Conducting at least quarterly face-to-face visits with each individual according to BIDD requirements; and

l. Making phone contacts at the frequency required by BIDD.

XVII.F.4. 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.

XVII.F.5. The maximum case load for a support coordinator is thirty-five (35) waiver participants.

XVII.F.6. Support coordinators cannot supervise or provide any other ID/DD Waiver service. Support coordination services must be distinctly separate from other ID/DD Waiver service(s) an agency provides.

XVII.F.7. Support coordinators are responsible for maintaining electronic files as required by the BIDD.

SECTION G- COMMUNITY RESPITE SERVICES

XVII.G.1. Community Respite Services are provided to individuals enrolled in the ID/DD Waiver. Community Respite services are designed to provide families/care givers a safe place in the community where they can take their family member on a short-term basis for the purpose of relieving the family or caretaker or to meet planned or emergency needs. Typically, community respite is provided at times when other types of services are not available such as evenings and weekends.

XVII.G.2. The expected outcome for Community Respite Services is that families receive relief from the constant demands of care giving.

XVII.G.3. Community respite services must be provided in a DMH certified site in the community.

XVII.G.4. Community respite cannot be provided over night.

XVII.G.5. Individuals attending a community respite program cannot be left unattended at any time.

XVII.G.6. Individuals must be engaged in chosen activities which are age appropriate during the provision of community respite.

XVII.G.7. Snacks and meals (including drinks must be provided at regular meal times (breakfast, lunch, and dinner). If the person arrives in between meal times, he/she must be offered at least one (1) drink and snack.

XVII.G.8. For every eight (8) 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.

SECTION H- IN-HOME RESPITE SERVICES

XVII.H.1. In-Home Respite Services are provided to individuals enrolled in the ID/DD Waiver. In-Home Respite services provide temporary, periodic relief to those persons normally providing the care for an eligible individual. Respite services are also provided when the usual care giver is absent or incapacitated due to hospitalization, illness, or injury or upon their death.

XVII.H.2. The expected outcome for In-Home Respite Services is that families receive relief from the constant demands of care giving.

XVII.H.3. In-home respite consists of one or more of the following types of services, depending on each individual's identified needs and according to individual's service plan:

a. Assistance with personal care needs such as bathing, dressing, grooming, and toileting;

b. Assistance with feeding and meal preparation;

c. Assistance with transferring/ambulation;

d. Play/leisure/socialization activities;

e. Taking the individual in the community for activities such as exercise, recreation, shopping, or other purposes;

f. Assistance in housekeeping directly related to the individual's health and welfare;

g. Other individualized activities specified on the individual's service plan.

XVII.H.4. In-Home Respite is used only for the purpose of relieving the participant's caregiver from the constant demands of caring for the individual. Activities outside the home cannot be the main purpose of the service.

XVII.H.5. This service is only available to individuals living in a family home residence and is not permitted for individuals living alone, in any type of group home, in any type of staffed residence, or with a roommate.

XVII.H.6. Individuals cannot be left unattended at any time during the provision of in-home respite.

XVII.H.7. Nurses who provide in-home respite must practice according the Mississippi Nurse Practice Act and Nursing Rules and Regulations.

SECTION I- BEHAVIOR SUPPORT AND INTERVENTION SERVICES

XVII.I. Behavior Support and Intervention Services are designed for individuals who exhibit behavior problems which cause them not to be able to benefit from other services being provided or cause them to be so disruptive in their environment(s) there is imminent danger of causing harm to themselves or other.

XVII.I.1 The expected outcome for Behavior Support and Intervention Services is for people to receive training and supports necessary to decrease maladaptive behaviors which interfere with individuals remaining at home and in the community.

XVII.I.2. Behavior Support and Intervention Services must include the following:

a. Assessing the individual's environment and identifying antecedents of particular behaviors, consequences of those behaviors, and maintenance factors for the behaviors;

b. Developing a positive behavior support plan;

c. Implementing the plan, collecting data, and measuring outcomes to assess the effectiveness of the plan;

d. Training staff and/or family members to maintain and/or continue implementing the plan;

e. Assisting the individual in becoming more effective in controlling his/her own behavior either through counseling or by implementing the behavioral support plan; and

f. Documentation of collaboration with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues

and to limit the need for psychotherapeutic medications, when applicable.

XVII.I.3. The Behavior Support Plan must be approved in writing as follows:

a. In day and residential programs, the behavior support plan must be approved by the following:

(1) The parent(s)/legal representative;
(2) The individual (if appropriate);
(3) The behavior support/interventionist;
(4) The director of the service; and
(5) The Executive Director of the program/agency or his/her designee.

b. If the individual is not enrolled in a day or residential program, the behavior support plan must be approved by the following:

(1) The parent(s)/legal representative;
(2) The individual (if appropriate); and
(3) The behavior support/interventionist.

XVII.I.4. Behavior Support and Intervention Services provided through the ID/DD Waiver cannot be provided in a public school setting. However, part of the assessment may include observing the person in the classroom setting.

a. The behavior support provider may not function as an assistant in the classroom by providing direct services.
b. If a behavior program is being implemented in the school setting by school personnel, the behavior support provider must document in the record the methods by which all parties are collaborating to ensure consistency of methods and agreement about outcomes.

PART XVIII

SUBSTANCE ABUSE PREVENTION AND REHABILITATION SERVICES

All sections contained in this part pertain specifically to services and supports that are available to individuals with substance abuse disorders or activities designed to prevent substance abuse.

Primary substance abuse treatment consists of the following: Primary Residential Treatment, General Outpatient, Intensive Outpatient (IOP), Inpatient Chemical Dependency Unit (CDU) and Specific Outpatient DUI program Tracks. Transitional Residential substance abuse treatment is also referred to as Secondary substance abuse treatment. The DMH Substance Abuse support service is Aftercare. Alcoholics Anonymous, Al-Anon, and other self-help groups are also considered substance abuse support services.

All alcohol and drug treatment and prevention programs that receive funds from and/or are certified by the DMH, Bureau of Alcohol and Drug Abuse must comply with the Standards in Parts I through VII.

SECTION A- GENERAL STANDARDS

XVIII.A.1. All DMH funded service providers of an alcohol and drug program must submit the Mississippi Substance Abuse Management Information System (MSAMIS) report to the DMH, Bureau of Alcohol and Drug Abuse by the tenth (10th) working day of the month following the reporting period.

XVIII.A.2. The program must have written policies and procedures for the discharge of an individual from a program including, but not limited to the following:

a. Successful completion of treatment;

b. Noncompliance with program rules and regulations;

c. Transfer of individual to another program;

d. Instances in which the individual leaves a program (self-declared discharge) against the advice/approval of program director or designee.

XVIII.A.3. All providers must provide and document that all individuals receiving primary substance abuse treatment receive a risk assessment for HIV at the time of intake. Those individuals determined to be high risk for HIV must be informed of available HIV testing resources. Transitional residential and

aftercare programs must also provide these services unless the program can provide documentation that the individual received the risk assessment and follow-up (as needed) during primary

substance abuse treatment. Individuals in a residential setting that volunteer to be tested must be offered transportation to an appropriate health care facility.

XVIII.A.4. All providers must provide and document that all individuals receiving primary substance abuse treatment receive a risk assessment for Tuberculosis (TB) at the time of intake. All appropriate TB tests (skin tests, chest x-rays) must be provided by the agency, or by an appropriate health care agency, to all individuals determined to be high risk. Transitional residential and aftercare programs must also provide these services unless the program can provide documentation that the individual received the risk assessment and follow-up (as needed) during primary substance abuse treatment. Individuals in a residential setting must be provided with necessary transportation.

XVIII.A.5. All providers must provide and document that all individuals receiving primary substance abuse treatment receive educational information concerning the following topics in a group and/or individual session.

a. HIV/AIDS;

(1) modes of transmission;
(2) Universal Precautions and other preventative measures against contracting/ spreading the virus;
(3) current treatments and how to access them.

b. Tuberculosis (TB);

(1) modes of transmission;
(2) current treatment resources and how to access them.

c. Sexually Transmitted Diseases (STDs);

(1) modes of transmission;
(2) precautions to take against contracting these diseases;
(3) progression of diseases;
(4) current treatment resources and how to access them.

XVIII.A.6. Transitional residential and aftercare programs must also provide the service outlined in Standard XVIII.A.5, unless the program can provide documentation that the individual received the educational information during primary substance abuse treatment.

XVIII.A.7. All substance abuse programs must give first priority to the acceptance and treatment of pregnant women. In residential programs, if a bed is not available, the program must refer the individual to another DMH certified program that does have the capacity to admit the individual. If residential treatment placement is not found, the individual must be assessed and referred, by the initial provider, to another appropriate substance abuse service and to a local health care provider for prenatal care until appropriate residential treatment is identified. This process must be completed within forty-eight (48) hours of the initial Intake/Assessment and documented by the initial service provider. Written documentation must be submitted to the DMH Bureau of Alcohol and Drug Abuse.

XVIII.A.8. The Joint Commission (TJC) accredited substance abuse treatment service providers (not funded by DMH) seeking DMH (DMH) certification must submit documentation of TJC accreditation in the specific substance abuse area(s) that corresponds (not to include DUI) with the substance abuse service area(s)included in the DMH Operational Standards Part VII, Section B and Part XVIII. The DMH will determine if the documentation is sufficient to support certification in the specific substance abuse services areas.

XVIII.A.9. DUI must be a separate accreditation from The Joint Commission.

XVIII.A.10. Intensive Outpatient Programs (IOP) must be limited to twelve (12) individuals per session.

XVIII.A.11. Caseloads for primary residential program staff must be no more than eight (8).

XVIII.A.12. 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.

XVIII.A.13. All programs must have a physical environment which provides designated space for privacy of individual and group counseling sessions.

SECTION B- DETOXIFICATION SERVICES

XVIII.B.1. Detoxification is the process through which a person who is physically and/or psychologically dependant on alcohol, illegal drugs, prescription medications, or a combination of these drugs is withdrawn from the drug or drugs of

dependence. Methods of detoxification include: medical detoxification, which is detoxification in a hospital setting, and social detoxification which is detoxification in a non-hospital supportive environment.

XVIII.B.2. Expected outcomes for Detoxification Services include:

a. Individuals are provided medical or social detoxification services.
b. Individuals are successfully and safely withdrawn from their drug or drugs of dependence.

XVIII.B.3. Primary residential programs providing detoxification services must have written policies and procedures which specify the following:

a. An individual designated as responsible for coordinating detoxification services.

b. A description of the method by which detoxification services are offered.

c. A description of the method by which referrals are made to physicians and/or hospitals for appropriate medical intervention.

XVIII.B.4. Following social detoxification under a physician's supervision, program personnel must do a bed check of each individual for signs or symptoms of psychological or physical withdrawal at least <u>every hour</u> for the first 24 hour period after admission; followed by a reduction to at least <u>every two (2) hours</u> for the following 24 hour period and, as needed, thereafter.

XVIII.B.5. Primary residential detoxification programs must have:

a. A licensed physician on staff and available on a twenty-four (24) hour basis through affiliation agreement/contract, who has admitting privileges at a local hospital; and

b. A written agreement or contract with a local hospital to provide inpatient detoxification services, including emergency services.

XVIII.B.6. Primary residential detoxification programs must have a written plan describing the handling of medical emergencies which includes the roles of staff members and physicians.

<u>SECTION C- OUTREACH/AFTERCARE SERVICES</u>

XVIII.C.1. Outreach services provide information on, encourage utilization of, and provide access to needed treatment or support services in the community to assist persons with alcohol/drug problems and/or their families. Aftercare services are designed to assist individuals who have completed primary substance abuse treatment in maintaining sobriety and achieving positive vocational, family, and personal adjustment. Aftercare also offers the individual with structured support and assistance which may include securing additional needed services from community mental health centers or from other health/human service providers and maintaining contact and involvement with the individual's family.

XVIII.C.2. Expected outcomes for Outreach/Aftercare Services include:

a. Individuals receive needed assistance finding access to substance abuse treatment and other support services in the community.
b. Individuals receive Aftercare Services in order to maintain sobriety.

XVIII.C.3. The program must establish and implement written policies and procedures and documentation that the following outreach/aftercare services are available to adults:

a. Structured and organized group meetings with outreach/aftercare worker a minimum of one (1) hour per week on a consistent basis;

b. Individual sessions with outreach/aftercare worker, as needed;

c. Family sessions with outreach/aftercare worker, as needed;

d. Employer contacts, as needed; and

e. Referrals and linkage with additional needed services.

XVIII.C.4. Outreach/aftercare staff must make at least one (1) attempt to contact each member per month. Group or individual sessions are acceptable as contacts.

XVIII.C.5. The outreach/aftercare worker must maintain on site a comprehensive file of existing community resources. Each listed resource must include:

a. The name, location, telephone number and hours of operation of the resource;

b. The types of services provided by the resource;

c. Eligibility requirements; and

d. Contact person(s).

XVIII.C.6. The outreach/aftercare worker must conduct community outreach activities to educate their community about substance abuse treatment and prevention services offered through their organization. Documentation of these activities must be kept in a log listing a brief description of the audience receiving the outreach contact/activity, type of contact/activity, date, and number of participants.

XVIII.C.7. Aftercare Services must be provided to individuals in their respective catchment areas regardless of where the Primary Treatment Services have been completed.

SECTION D- PREVENTION SERVICES

XVIII.D.1. 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 and related problem behaviors to provide immediate and long-term positive results.

XVIII.D.2. Expected outcomes for Prevention Services include:

a. Individuals experience a reduction in risk factors linked to Alcohol, Tobacco and Other Drugs (ATOD).
b. Individuals experience an increase in protective factors linked to ATOD.
c. Evidence based curricula are being utilized.

XVIII.D.3. 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.

a. Information/dissemination;

b. Affective education programs;

c. Alternative programs;

d. Problem/Identification and referral;

e. Community-based process (Community development);

f. Environmental programs.

XVIII.D.4. All providers of prevention services must document all prevention activities on the designated Internet-based tool or other required tool by the 10th working day of the month following the reporting period.

XVIII.D.5. All prevention providers must have a staff member designated to coordinate the prevention program. This is in accordance with RFP guidelines and contracts.

XVIII.D.6. 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). The percentage of implementation to an evidence-based curriculum must adhere to BADA grant requirements.

XVIII.D.7. No prevention services will be provided to persons who are actively engaged in any alcohol and drug abuse treatment program on a continuous basis or as part of an ongoing program.

XVIII.D.8. Individuals working in prevention services must have their own working computer (provided by the agency) with Internet access in order to keep abreast of the most current model, evidence-based prevention technology.

SECTION E- DUI DIAGNOSTIC ASSESSMENT SERVICES FOR SECOND AND SUBSEQUENT OFFENDERS

XVIII.E.1. 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.

XVIII.E.2. The expected outcome for DUI Diagnostic Assessment Services is that individuals who are eligible for the DUI Track, are given an approved diagnostic assessment prior to substance abuse treatment to determine the most appropriate type of treatment modality.

XVIII.E.3. 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.

XVIII.E.4. The program must have written policies and procedures and adhere to those policies and procedures which describe:

a. Addressing DUI assessments for individuals completing primary treatment from non-DMH certified treatment programs.

b. The criteria by which the treatment environment is determined.

c. The criteria by which successful completion of treatment is determined for DUI offenders.

d. The process by which an individual is admitted into a substance abuse treatment program following completion of the DUI diagnostic assessment.

XVIII.E.5. The DUI diagnostic assessment (see components in Standard XVIII.E.6) must be administered and evaluated prior to treatment.

XVIII.E.6. The DUI diagnostic assessment must consist of the following components and be documented in the individual's case file;

a. 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

b. Results & interpretation of the SASSI, or other DMH Bureau of Alcohol and Drug Abuse approved tool. If certification is required, at least one staff member must be certified to administer the diagnostic tool.

XVIII.E.7. Individuals receiving DUI assessment/treatment services through a Specific DUI Outpatient Program Track must receive a minimum of twenty (20) hours of direct service (individual and/or group therapy), or as otherwise specified by the DMH Bureau of Alcohol and Drug Abuse, before receiving the DMH Certification of DUI In-Depth Diagnostic Assessment and Treatment Form.

Documentation of treatment will be maintained in the individual's case record.

XVIII.E.8. 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 Bureau of Alcohol and Drug Abuse when an individual has successfully completed the treatment program within ten (10) working days.

XVIII.E.9. All DUI Diagnostic Assessment services must be equipped to provide each individual the type of substance abuse treatment indicated by the results and interpretation of the assessment (components listed in this section above). Substance abuse treatment may be offered through the assessment service and/or through an affiliation agreement with a DMH certified substance abuse treatment program. The assessment service must be able to provide, at a minimum, outpatient and primary residential or inpatient chemical dependency substance abuse treatment.

~~MISSISSIPPI DEPARTMENT OF MENTAL HEALTH~~

~~MINIMUM STANDARDS FOR COMMUNITY MENTAL HEALTH/ MENTAL RETARDATION SERVICES~~

Operational Standards
for
Mental Health,
Intellectual/Developmental Disabilities,
and Substance Abuse
Community Service Providers

~~2002 REVISION~~
~~Effective July 1, 2002~~

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STATUTORY AUTHORITY

The Mississippi Department of Mental Health (hereafter referred to as "DMH") is the state agency charged with administering the public system of mental health, ~~mental retardation~~ intellectual/developmental disabilities, alcohol/ drug abuse services, and Alzheimer's disease and other dementia services. The agency was created in 1974 by an Act of the Mississippi Legislature, Regular Session. The creation, organization and duties of the Mississippi Department of Mental Health are defined under Sections 41-4-1 through 41-4-~~23~~ 27.

The State of Mississippi vested standard-setting authority in the Mississippi State Department of Mental Health through Section 41-4-7 of the *Mississippi Code, 1972, Annotated,* which authorizes the Department to:

X supervise, coordinate, and establish standards for all operations and activities of the state, related to mental health and providing mental health services (Section 41-4-7 (c));

X certify, coordinate and establish minimum standards and establish minimum required services for regional mental health and ~~mental retardation~~ intellectual disability commissions and other community service providers for community or regional programs and services in mental health, ~~mental retardation~~ intellectual disability, alcoholism, drug misuse, developmental disabilities, compulsive gambling, addictive disorders and related programs throughout the state (Section 41-4-7 (f)); and,

X establish and promulgate reasonable minimum standards for the construction and operation of state and all Department of Mental Health 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, ~~mental retardation~~ intellectual disability , alcoholism, drug misuse and developmental disabilities (See Section 41-4-7(g)).

Scope

The Mississippi Department of Mental Health *Operational Standards for Mental Health. Intellectual/Developmental Disabilities and Substance Abuse Community Service Providers* serves as the standards/minimum standards referred to in Section 41-4-7 (c), Section 41-4-7 (f) and Section 41-4-7 (g) mentioned above. This revision of standards will be effective January 1, 2011.

MISSION

The mission of the DMH is supporting a better tomorrow by making a difference in the lives of Mississippians with mental illness, substance abuse problems, and intellectual or developmental disabilities one person at a time.

VISION

We envision a better tomorrow where the lives of Mississippians are enriched through a public mental health system that promotes excellence in the provision of services and supports.

A better tomorrow exists when…

- All Mississippians have equal access to quality mental health care, services and supports in their communities.
- People actively participate in designing their services.
- The stigma surrounding mental illness, intellectual/developmental disabilities, substance abuse and dementia has disappeared.
- Research, outcome measures, and technology are routinely utilized to enhance prevention, care, services and supports.

PHILOSOPHY

The Department of Mental Health is committed to developing and maintaining a comprehensive, statewide system of prevention, service, and support options for adults and children with mental illness or emotional disturbance, with alcohol/drug problems, and/or ~~mental retardation~~ intellectual disabilities or developmental disabilities, as well as adults with Alzheimer's disease and other dementia. The Department supports the philosophy of making available a comprehensive system of services and supports so that individuals and their families have access to the least restrictive and appropriate level of services and supports that will meet their needs. ~~The Department strives to maintain high standards and to continually improve the availability, accessibility, and quality of services provided through this public system. The Department has attempted to do this by developing an array of community programs that will provide services and supports to individuals as close to their homes and communities as possible. The Department also hopes to prevent or reduce unnecessary use of inpatient or institutional services when individual needs can be met with less intensive or less restrictive levels of care. This philosophy requires that a continuum of services and supports be available for individuals, since research shows that unless such a continuum is available, individual services provided in isolation are usually less effective.~~

~~Underlying these efforts is the belief that all components of the system should be person-centered and built on individuals' and their families' strengths while also meeting their~~

~~needs for special services and support.~~ Our system is person-centered and is built on the strengths of individuals and their families while meeting their needs for special services. DMH strives to provide a network of services and supports for persons in need and the opportunity to access appropriate services according to their individual needs/strengths. DMH is committed to preventing or reducing the unnecessary use of inpatient or institutional services when individuals' needs can be met with less intensive or least restrictive levels of care as close to their homes and communities as possible. Underlying these efforts is the belief that all components of the system should be person-driven, family-centered, community-based, results and recovery/resiliency oriented.

~~In accomplishing its mission of developing an accessible, comprehensive service and support system for individuals with mental illness, alcohol and drug abuse problems, Alzheimer's disease and other dementia, and/or mental retardation and developmental disabilities, the Department of Mental Health is committed to its obligation to effectively administer its human and fiscal resources, identify and communicate existing needs, and advocate for resources to meet those needs.~~

VALUES AND GUIDING PRINCIPLES

People We believe people are the focus of the public mental health system. We respect the dignity of each person and value their participation in the design, choice and provision of services to meet their unique needs.

Community We believe that community-based service and support options should be available and easily accessible in the communities where people live. We believe that services and support options should be designed to meet the particular needs of the person.

Commitment We believe in the people we serve, our vision and mission, our workforce, and the community-at-large. We are committed to assisting people in improving their mental health, quality of life, and their acceptance and participation in the community.

Excellence We believe services and supports must be provided in an ethical manner, meet established outcome measures, and be based on clinical research and best practices. We also emphasize the continued education and development of our workforce to provide the best care possible.

Accountability We believe it is our responsibility to be good stewards in the efficient and effective use of all human, fiscal, and material resources. We are dedicated to the continuous evaluation and improvement of the public mental health system.

Collaboration We believe that services and supports are the shared responsibility of state and local governments, communities, family members, and service providers. Through open communication, we continuously build relationships and partnerships with the people and families we serve, communities, governmental/nongovernmental entities and other service providers to meet the needs of people and their families.

Integrity We believe the public mental health system should act in an ethical, trustworthy, and transparent manner on a daily basis. We are responsible for providing services based on principles in legislation, safeguards, and professional codes of conduct.

Awareness We believe awareness, education, and other prevention and early intervention strategies will minimize the behavioral health needs of Mississippians. We also encourage community education and awareness to promote an understanding and acceptance of people with behavioral health needs.

Innovation We believe it is important to embrace new ideas and change in order to improve the public mental health system. We seek dynamic and innovative ways to provide evidence-based services/supports and strive to find creative solutions to inspire hope and help people obtain their goals.

Respect We believe in respecting the culture and values of the people and families we serve. We emphasize and promote diversity in our ideas, our workforce, and the services/supports provided through the public mental health system.

~~PART I~~

~~PROCEDURES FOR CERTIFICATION~~

PART I

PROCEDURES FOR CERTIFICATION

Providers seeking DMH certification of any type must follow procedures outlined in this Part and its subsequent Sections A-L. In order to be certified by the Mississippi DMH, the provider must have sufficient safeguards in place to assure that all program components operate in an ethical, moral, legal and professional manner. This requirement includes training of all program staff and volunteers (executive level down) regarding the ethical treatment of individuals served by the program, as well as proper use of program and individual funds/grants.

SECTION A - CERTIFICATION OPTIONS

Service provider organizations seeking certification or recertification by the Mississippi ~~Department of Mental Health~~ DMH are categorized in these standards by designations related to such factors as their status as a governmental/nongovernmental entity, source of funding, and/or statutory and other regulatory requirements governing certification. Applicants must indicate on the Application for Certification form (pp. ~~19-20~~ 14-15) the designated option under which they are seeking certification. Programs with certain designations may be charged a fee for certification. (Refer to Section B-Fees, that follows.)

NOTE: Certification by the Mississippi ~~Department of Mental Health~~ 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. ~~Time lines indicated in days throughout this document refer to calendar days unless otherwise specified.~~

NOTE: Certification by the Mississippi DMH of any type is not a guarantee of designation as a DMH designated Community Mental Health/Intellectual Disability Center.

Providers seeking certification or recertification that meet all application procedure requirements and minimum standards herein will receive a Certificate of Operation, valid

for ~~the time period and services specified on the certificate~~ three (3) years , with one of the following designations:

1. 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 programs, including those community mental health service providers meeting DMH requirements of and determined necessary by DMH to be an approved community mental health~~/mental retardation~~ center, operated by the state regional centers and the state psychiatric/chemical dependency hospitals. These programs must follow procedures in Part I and meet all standards in Parts ~~II and III as well as all applicable standards in Parts IV through X~~ Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

   ~~Recertification of DMH/D programs is required every two (2) years.~~

3. 2. DMH/CMHC (DMH/C): Programs that are certified under this option are community mental health/mental retardation 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 ~~an~~ a designated and approved mental health~~/mental retardation~~ center. These programs must follow procedures in Part I and meet all standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

   ~~Providers seeking DMH/C certification must follow procedures in Part I and meet all standards in Parts II and III, as well as all applicable standards in Parts IV through X that apply to the specific service(s) for which they are seeking certification~~.

   ~~Recertification of DMH/C programs is required every two (2) years~~.

3. DMH/Grants (DMH/G): Programs other than those designated as DMH/D and DMH/C above that receive funds for services through grants from the Mississippi Department ~~of Mental Health~~ DMH must be certified. These include nonprofit programs that receive funds directly from the ~~Department of Mental Health~~ DMH, but that are not community mental health centers (DMH-C designation) or ~~Department of Mental Health~~ DMH-operated programs (DMH/D designation). These programs must follow procedures in Part I and meet all standards in Parts II ~~and III~~ through VII, as well as all applicable standards in Parts ~~IV~~ VIII through ~~X~~ XVIII that apply to the specific service(s) for which they are seeking certification.

~~Recertification of DMH/G programs is required every two (2) years.~~

4. DMH/Home and Community-Based Waiver (DMH/H): Programs meeting requirements for certification to provide services under the Home and Community-Based Services ~~MR~~ ID/DD Waiver must be certified. Programs/agencies that may apply include those already certified by the DMH as well as other agencies that provide the type services offered through the HCBS Waiver. Any program/agency applying must follow the procedures in Part I and meet all standards in Parts II~~, III, and IV~~ through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

   ~~Recertification of DMH/H programs is required every two (2) years.~~

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

   All other providers seeking certification by the Mississippi Department of Mental Health which are not designated under the DMH/D, DMH/C, DMH/G, or DMH/H options will be designated as DMH/O programs. These include those programs without external requirements for certification by the Mississippi Department of Mental Health that seek certification voluntarily, such as for additional assurance to the public that they meet State ~~minimum~~ operational standards for provision of services.

   ~~Programs seeking certification under DMH/O option must follow procedures in Part I and meet all standards in Parts II and III as well as all standards in Parts IV through X that apply to the specific service(s) for which they are seeking certification.~~ These programs must follow procedures in Part I and meet all standards in Parts II through VII, as well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

   Providers seeking certification required by the Mississippi Department of Finance and Administration for service provision under the State Employee Health Insurance Plan must meet state qualifications set forth in the Plan~~, follow procedures in Part I, and meet requirements in Parts II, III, and IV-X that apply to the specific service(s) for which they are seeking certification.~~ These programs must follow procedures in Part I and meet all standards in Parts II through VII, as

well as all applicable standards in Parts VIII through XVIII that apply to the specific service(s) for which they are seeking certification.

~~Annual recertification of DMH/O programs is required~~.

SECTION B - FEES

A fee may be charged by the ~~Mississippi Department of Mental Health~~ 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 ~~Mississippi Department of Mental Health~~ DMH notifying the provider of the fee (if applicable). The fee must be submitted to the ~~Mississippi Department of Mental Health~~ DMH prior to the initial on-site visit.

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

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.

SECTION C - MINIMUM REQUIRED ~~LEVELS OF~~ SERVICES

The ~~Department of Mental Health's~~ DMH's philosophy supports making available to Mississippians a continuum or array of treatment and support services that are accessible on a statewide basis. Establishment of minimum required services is necessary to develop a comprehensive system of care. ~~Services listed are defined in Parts IV-X of these standards. Unless otherwise specified, population data will be based on the most current available U.S. Census data for Mississippi.~~

I. Community Mental Health/Mental Retardation Centers operated 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 DMH requirements of and are determined necessary by DMH to be ~~an~~ a designated and approved mental health~~/mental retardation~~ center (DMH/C) must provide the following minimum services throughout the CMHC's entire catchment area :

A. Adult Mental Health Services

1. Outpatient Therapy
2. Case Management
3. Psychiatric/Physician Services
4. Emergency/Crisis Services
5. Psychosocial Rehabilitation
6. Inpatient Referral
7. Support for Family Education Services
8. Support for Consumer Education Services
9. Pre-Evaluation Screening for Civil Commitment (required only for centers operated by regional commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*)

B. Children and Youth Mental Health Services

1. Day Treatment
2. Outpatient Therapy
3. Case Management
4. Psychiatric/Physician Services
5. Intake/Functional Assessment
6. Emergency/Crisis Services
7. Pre-Evaluation Screening for Civil Commitment (for youth age 14 and over) (required only for centers operated by regional commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*)

C. Alcohol and Drug Abuse Services

1. Outpatient Therapy
2. Primary Residential Treatment (adults)
3. DUI Assessment
4. Outreach/Aftercare
5. Prevention Services

D. ~~Mental Retardation~~ Intellectual/Developmental Disabilities Services

Case Management ~~(direct services or through affiliation agreement)~~
Emergency/Crisis Services

II. ~~Community Mental Health/Mental Retardation Centers operated 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 DMH requirements of and are determined necessary by DMH to be an approved mental health/mental retardation center (DMH/C) must provide the following minimum services at the level of services specified:~~

~~NOTE: Unless otherwise specified, the approving authority referenced below is the DMH.~~

~~A. Community Mental Health Services for Adults~~

~~1. Psychosocial Rehabilitation (defined in this section as Psychosocial Rehabilitation/Clubhouse, Psychosocial Elderly, or Day Support): The minimum required service level for psychosocial rehabilitation for adults will be determined as follows:~~

~~a. The total number of certified slots (DMH-certified capacity) will be determined as of a given date specified by the Department).~~

~~b. A statewide average of the number of DMH-certified slots for psychosocial rehabilitation per 100,000 adult population will be determined.~~

~~c. A Regional Community Mental Health/Retardation Center (DMH/C) will be considered in compliance with the minimum required service level for psychosocial rehabilitation for adults if the number of DMH-certified slots (certified capacity) in the region served by the center per 100,000 adult population is within the range of 20 percent above or 20 percent below the statewide average of certified capacity for psychosocial rehabilitation for adults per 100,000 adult population.~~

~~d. The statewide average number of DMH-certified slots (certified capacity) for psychosocial rehabilitation will be recalculated every two (2) years.~~

~~2. Case Management: Adults with serious mental illness receiving substantial public assistance (defined as adults 18 years and older receiving Medicaid) must receive or be offered case management. For those individuals in need of, but declining case management,~~

~~documentation must be on file that the individual has declined the service. This documentation must be obtained at least annually.~~

~~The minimum required service level for mental health case management for adults will be determined as follows:~~

~~a. The total number (Full Time Equivalent, FTE's) statewide of Regional Mental Health/Mental Retardation Centers' (DMH/C) case managers for adults will be determined (as of a given date specified by the Department), based on reports by the community mental health centers.~~

~~b. The statewide average of the number (FTE's) of mental health case managers for adults per 100,000 adult population will be determined.~~

~~c. The Regional Community Mental Health/Mental Retardation Center (DMH/C) will be considered in compliance with the minimum required service level for case management if the number (FTE's) of mental health case managers in the region served by the center per 100,000 adult population is within the range of 20 percent above or 20 percent below the statewide average of mental health case managers for adults per 100,000 adult population.~~

~~d. The statewide average number (FTE's) for mental health case managers for adults will be recalculated every two (2) years.~~

~~3. Psychiatric/Physician Services: The minimum required service level for psychiatric/physician services for adults with mental illness will be determined as follows:~~

~~a. The total number (FTE's) statewide of psychiatrists/ physicians for adults will be determined (as of a given date specified by the Department), based on reports by the Regional Community Mental Health/Mental Retardation Centers (DMH/C).~~

~~b. A statewide average of the number (FTE's) of psychiatrists/ physicians for adults per 100,000 adult population will be determined.~~

c. A Regional Community Mental Health/Mental Retardation Center (DMH/C) will be considered in compliance with the minimum required service level for psychiatrists/physicians for adults with mental illness if the number (FTE's) of psychiatrists/physicians in that region per 100,000 adult population is within the range of 20 percent above or 20 percent below the statewide average of psychiatrists/physicians for adults per 100,000 adult population.

d. The statewide average number (FTE's) of psychiatrists/physicians will be recalculated every two (2) years.

4. Emergency Services must be available on a 24 hour a day basis throughout all counties in the region.

5. Inpatient Referral Services must be available within the region.

6. Outpatient Therapy (individual, group, family and/or multi-family group therapy): The prescribed range of service level for outpatient mental health therapy will be determined as follows:

a. The total number (FTE's) of outpatient therapists statewide will be determined, based on reports by community mental health centers as of a given date established by the Department.

b. From the total (in 6. a.), a statewide average number of outpatient mental health therapists per 100,000 population will be calculated.

c. A Regional Community Mental Health/Mental Retardation Center will be considered in compliance with the minimum required service level if the number of outpatient mental health therapists in that region per 100,000 population of the region is within the range of 20 percent above or 20 percent below the statewide average (FTE's) of outpatient mental health therapists per 100,000 population.

d. The minimum required service level for outpatient mental health therapists will be recalculated every two (2) years.

7. Support for the family education program must be provided within the region as approved by the Department of Mental Health in the annual operational plan submitted by the local Regional

Community Mental Health/Mental Retardation Center (DMH/C). (Refer to Part II, Section A – Governing Authority, 11.1-11.5 for requirements pertaining to annual operational plans.)

8. Support for the consumer education program must be provided within the region as approved by the Department of Mental Health in the annual operational plan submitted by the local Regional Community Mental Health/Mental Retardation Center (DMH/C). (Refer to Part II, Section A – Governing Authority, 11.1-11.5 for requirements pertaining to annual operational plans.)

9. Pre-evaluation Screening for Civil Commitment Services must be available in all counties in the region. (Required only for centers operated by regional commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*)

B. Community Mental Health Services for Children

Population statistics referenced in this section include youth to 18 years.

1. Day Treatment: The minimum required service level for day treatment services will be determined as follows:

   a. The current total of certified day treatment programs in Mississippi will be determined (as of a given date specified by the DMH).

   b. A statewide average number of day treatment programs per 100,000 child population in each Regional Community Mental Health/Mental Retardation Center (DMH/C) will be calculated from this total (in 1. a. above)

   c. A Regional Community Mental Health/Mental Retardation Center (DMH/C) region will be considered in compliance with the minimum required service level if the number of day treatment programs per 100,000 child population in that region is within a range of 20 percent above or 20 percent below the average number of day treatment programs available per 100,000 population statewide (as of a given date specified by DMH).

   d. The statewide average of day treatment programs (in 1.c.) will be recalculated every two (2) years, and the minimum required service level will be adjusted accordingly.

e. Additionally, at a minimum, one (1) children's day treatment program must be available at a school site in each school district in a region served by a Regional Community Mental Health/Mental Retardation Center (DMH/C).

If the school district does not accept the provider's offer to provide day treatment services, written documentation of nonacceptance (for the current school year) by the school district superintendent must be on file at the community mental health center for review by DMH personnel.

2. Outpatient Therapy (individual, group, family and/or multi-family group therapy): The prescribed range of service level for outpatient mental health therapy for children will be determined as follows:

a. The total number (FTE's) of outpatient therapists serving children and adolescents statewide will be determined, based on reports by community mental health centers as of a given date established by the Department.

b. From the total (in 2. a.), a statewide average number of children's outpatient mental health therapists per 100,000 child population will be calculated.

c. A Regional Community Mental Health/Mental Retardation Center (DMH/C) will be considered in compliance with the minimum required service level if the number of children's outpatient mental health therapists in that region per 100,000 child population of the region is within the range of 20 percent above or 20 percent below the statewide average (FTE's) of children's outpatient mental health therapists per 100,000 child population.

d. The minimum required service level for children's outpatient mental health therapists will be recalculated every two (2) years.

e. Additionally, at a minimum, one outpatient therapist for children must be available at a school site in each public school district in the region served by the Community Mental Health/Mental Retardation Center (DMH/C).

~~If the school district does not accept the provider's offer to provide outpatient services, written documentation of nonacceptance (for the current school year) by the school district superintendent must be on file at the community mental health center for review by DMH personnel.~~

3. ~~Case Management: Children with serious emotional disturbance (SED) receiving substantial public assistance (defined as youth up to age 21 years receiving Medicaid who meet current criteria for serious emotional disturbance as specified in Part VI-Mental Health Services for Children and Youth, Section A-General Standards) must be offered case management. For those declining, documentation must be on file that the parent(s) or other legal custodian(s) have declined the service, at least annually.~~

4. ~~Psychiatric/Physician Services: The minimum required service level for psychiatric/physician services for children and youth with serious emotional disturbance will be determined as follows:~~

   a. ~~The total number (FTE's) statewide of psychiatrists/ physicians for children and youth will be determined (as of a given date specified by the Department), based on reports by the Regional Community Mental Health/Mental Retardation Centers (DMH/C).~~

   b. ~~A statewide average of the number (FTE's) of psychiatrists/ physicians for children per 100,000 child population will be determined.~~

   c. ~~A Regional Community Mental Health/Mental Retardation Center (DMH/C) will be considered in compliance with the minimum required service level for psychiatrists/physicians for children and youth with mental illness if the number (FTE's) of psychiatrists/physicians in that region per 100,000 child population is within the range of 20 percent above or 20 percent below the statewide average of psychiatrists/ physicians for children per 100,000 child population.~~

   d. ~~The statewide average number (FTE's) of psychiatrists/ physicians will be recalculated every two (2) years.~~

5. ~~Intake and Functional Assessment approved by the Department of Mental Health must be available in all counties throughout the region.~~

6. Emergency Services must be available on a 24 hour a day basis in all counties throughout the region.

7. Pre-evaluation Screening for Civil Commitment services must be available in all counties throughout the region (for youth 14 years and above). (Required only for centers operated by regional commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*)

C. Community Mental Health Alcohol and Drug Abuse Services

1. Outpatient Treatment Services must be provided at each satellite office in each mental health region. At least one staff member from each office will provide substance abuse treatment. Services will be measured as follows:

a. A current average level of service will be established by the DMH, Division of Alcohol and Drug Abuse (DADA), based upon the number of units of service available through the Substance Abuse Prevention and Treatment (SAPT) Block Grant.

b. The resulting statewide average number of units will be applied to each region by multiplying the total number of units received by the DMH, times the adult population of each region expressed in units of 100,000 individuals.

c. The results will yield the number of units of outpatient services each region is expected to deliver during the fiscal year.

d. If a region delivers less than 80% of its expected number of units of service, it will be required to submit a plan to increase service.

2. Primary Residential Services - (Adults)

The minimum required service level for substance abuse primary residential services will be determined as follows:

a. The total number of primary residential beds, statewide, will be determined based upon reports by the community

mental health centers as of a given date specified by the Department.

b. A statewide average number of primary residential beds per 100,000 population will be determined.

c. A community mental health region will be considered in compliance if the number of primary residential beds in that region per 100,000 population of the region is within the range of 20% above or 20% below the statewide average of primary residential beds per 100,000 population.

d. If the number of primary residential beds is below 20% of the statewide average the region must submit a plan to increase their bed capacity.

e. The statewide average number of primary residential beds will be recalculated every two (2) years.

3. DUI Assessment services for second and subsequent offenders must be available throughout the Mental Health/Mental Retardation Center (DMH/C) region.

4. Outreach/Aftercare Support Services must be available throughout the Mental Health/Mental Retardation Center (DMH/C) region when primary substance abuse services are provided.

5. Prevention Services must be available throughout the Mental Health/ Mental Retardation Center (DMH/C) region. Each regional mental health center will designate a Prevention Specialist/Coordinator to operate the program.

D. Community Mental Retardation/Developmental Disabilities Services

All community mental health/mental retardation centers certified by the Department of Mental Health must provide Case Management Services to individuals with mental retardation/developmental disabilities, or a written agreement with a Department of Mental Health regional center for persons with mental retardation to provide case management services in specific counties must be on file and updated annually.

III. Other Community Service Providers Certified by the Department of Mental Health

The minimum required level(s) of service(s) required of Department of Mental Health funded providers other than Regional Community Mental Health/Mental Retardation Centers described in I. and providers certified under the DMH/H option will be set forth in grants, purchase of service contracts, and/or annual operational plans approved on an individual basis by the Department of Mental Health.

SECTION D - APPLICATION FOR CERTIFICATION GUIDELINES

I. Certification Terminology

The following are some of the major terms used throughout the certification process described in this section. Providers interested in pursuing Mississippi Department of Mental Health certification should become familiar with these terms.

A. Days - Time lines indicated throughout this document refer to calendar days unless otherwise specified.

B. Department - Throughout this document, the Mississippi Department of Mental Health may also be referred to as the Department.

C. Certification Review Team - Staff assigned by the Mississippi Department of Mental Health to review and evaluate provider programs and/or programs seeking DMH certification in order to determine compliance with state law and agency standards. Final determination of compliance is recommended by the appropriate Bureau's Division of Accreditation and Licensure with the collaboration of the Certification Review Team.

D. Certification Visit - An actual on-site visit to the program and site(s) by the Certification Review Team as a result of the program's application for initial certification or for the purpose of conducting a review for recertification. This visit will take place on a biennial or annual basis, depending on the length of the period of certification. For example, a community mental health center would receive a Certification Visit at least every two years. (See above Part I, Section A – Certification Options.)

E. Follow-Up Visit - An actual on-site visit to the program/service site(s) by the Certification Review Team to determine implementation of an approved Plan of Correction (see below) and correction of any

deficiencies found on the Certification Visit (above) in accordance with time lines in the Plan of Correction. Information received through the grievance/complaint process operated by the Mississippi Department of Mental Health, Office of Constituency Services, may also result in a Follow-Up Visit if a potential violation of minimum standards is suspected.

F. Review Visit - An actual on-site visit that occurs at least one year after a Certification Visit (for programs under certification options with two-year certification periods). Components assessed during this visit include minimum standards pertaining to environment and safety (Part III, Section A) and case records management (Part III, Section E and other records requirements applicable to specific service areas) and may also include other areas addressed in these standards (such as continued compliance with plans of correction, management and programmatic standards, and assessment of satisfaction of individuals receiving services).

G. Exit Interview (not mandatory) - A face-to-face meeting held by the Certification Review Team with representatives of the provider for which an on-site visit has been conducted. Typically, the exit interview would occur on the last day of the visit and include a verbal overview of program strengths and potential findings which are likely to be included in the Review Report.

H. Review Report - A written report from the Department of Mental Health of findings and any required actions of the provider, based upon site visits or other reviews.

I. Certificate of Operation - Following final determination of compliance with all applicable minimum standards, a document called a Certificate of Operation is issued to a provider by the Mississippi Department of Mental Health, specifying the service(s) for which the provider is certified. This Certificate of Operation is valid for a one- or two-year period, as appropriate, in accordance with the designated option for which the provider is certified. (See Section A - Certification Options.)

Providers of services at a single site will receive a Certificate of Operation which lists all certified programs and services.

There are two types of Certificates of Operation for providers of services at multiple sites: (1) a certificate that lists all programs and services for which the provider is certified that must be displayed at the provider's main administrative office; and, (2) a certificate that indicates certification of a single program and/or physical location (site) that must be displayed

~~at the physical location of the program/service. (See Section I for more information about certificates of operation.)~~

~~J. Plan of Correction - A written report submitted by the provider to the Mississippi Department of Mental Health outlining courses of action and time lines for implementation of a plan to correct deficiencies in minimum standards found during on-site visits. Failure to implement approved Plans of Correction can result in denial or loss of certification.~~

~~K. Critical Standard - A Critical Standard is defined as a standard which is crucial to the health, welfare and/or safety of the individuals receiving services. For example, standards designated as Critical (γ) include those standards obviously addressing health, welfare or safety such as (but not limited to) the standards in Part III, Section G - Transportation or in Part III, Section A – Environment and Safety. If deficiencies are found in implementation of any Critical standard, the Certificate of Operation may be revoked from the date of notification by the Department to the Executive Officer or his or her designee of the program provider.~~

~~L. Category 1 Standard - A Category 1 Standard is a standard that is crucial to the outcome for individuals being served in a specific service. All deficiencies cited on Category 1 Standards must be corrected by the providers seeking recertification within the time period specified in the approved Plan of Correction, not to exceed 45 days as determined by the Department of Mental Health. Category 1 Standards are designated by a (*)~~

~~M. Category 2 standard - All minimum standards not designated herein by a (γ)as Critical or by an (*) as Category 1 Standards will be designated as Category 2 Standards. Category 2 Standards are also important and all deficiencies cited on Category 2 standards must be corrected within the time period specified in the approved Plan of Correction, not to exceed 90 days as determined by the Department of Mental Health from the notification of the deficiencies in the Review Report. These deficiencies must be corrected before proceeding with certification/recertification.~~

~~II.~~ Initial Application Process

A. All applicants for initial certification or certification of additional service(s) must complete an appropriate Application for Certification form, including any attachments as indicated. Refer to application forms/attachments in Part I, ~~Section D, III~~. Standard I.D.3. Application Forms that follows.

B. Application forms and any required fees must be submitted to the Division of Accreditation and Licensure. ~~in the appropriate service bureau depending on the primary service(s) for which certification is requested, as follows:~~

~~1. Bureau of Mental Health, Division of Accreditation and Licensure: Mental health (adult or child), alcohol/drug abuse (adult or child), and Alzheimer's disease/other dementia.~~

~~2. Bureau of Mental Retardation, Division of Accreditation and Licensure: Mental Retardation or Developmental Disabilities (adult or child) and Home and Community Based Waiver services.~~

C. All inquiries regarding certification, ~~unless otherwise indicated in these standards,~~ should be directed to the ~~appropriate bureau/division described in B. above.~~ Division of Accreditation and Licensure.

D. Upon written request, the ~~Department of Mental Health~~ DMH may provide technical assistance to the applicant preparing for certification.

E. Prior to the completion of the application process, all applicants seeking certification, except those to be designated as DMH/D and DMH/C providers established under the Regional Commission Act (Section 41-19-31 et seq., *Mississippi Code 1972, Annotated*), must be incorporated in Mississippi and have an established office physically located in Mississippi.

If the application is complete to include all required documentation, the certification process continues as described in Standard I.E.4.

Providers denied certification/recertification by the DMH may reapply for certification in accordance with Part I, Sections D and E. Providers may apply for certification/recertification only twice during a twelve (12) month period.

~~F. Applicants that do not hold any Department of Mental Health certification and are applying for initial certification must submit an Application for Certification form indicating that they are applying for initial certification. This form, with any attachments as indicated, must be submitted to the Division of Accreditation and Licensure in the appropriate bureau. (See B above.)~~

Application Process for Requesting Additional Services:

Applicants that currently hold valid certification by the ~~Department of Mental Health~~ DMH for some services and that are applying for certification of additional or different types of services must submit an Application for Certification form, indicating on the form that the application is for additional services. This form, with any attachments as indicated, must be submitted to the Division of Accreditation and Licensure ~~in the appropriate bureau. (See B. above.)~~

Applicants currently holding valid certification by the Department of Mental Health for a particular service at a particular site and service location that seek to open an additional or new program at the same site or physical location or at a different site or physical location must submit a separate Application for Certification Form for each new or additional program.

A separate application is required for each program, since staffing and physical facilities/environment/safety issues could potentially be different for each new or additional program, even if they are located in the same building.

For any program that is closed at one site and plans are to subsequently open or reopen a program at a different site, the program that is to be opened or reopened shall be considered a new or additional program. Therefore, in such cases, the provider must submit an Application for Certification Form for each new or additional program, even if the new or additional program is anticipated to serve some or all of the same individuals served in the closed program. ~~The Certificate of Operation for the program that is closed must be returned to the Department within 15 days of the last day individuals were served in the program, whether or not application for certification of a new or additional program Ato take the place of@ the closed program is made. (See also Part I, Section I.)~~

H. The Department may request additional information during review of the application. After reviewing the application, the ~~Department of Mental Health~~ DMH will notify the applicant regarding whether or not the application is acceptable and whether or not the certification process can proceed.

If the application is complete to include all required documentation the certification process continues as described in Standard I.E.4.

Providers denied certification/recertification by the DMH may reapply for certification in accordance with Part I, Sections D and E. Providers may apply for certification/recertification only twice during a twelve (12) month period.

~~I. Providers denied certification/recertification by the Department of Mental Health may reapply for certification in accordance with Section D - Application Guidelines.~~

III. Application Forms

A. Department of Mental Health Application for Certification.

~~B. Form I - Agreement for the Provision of Mental Retardation/Developmental Disabilities Services.~~

DEPARTMENT OF MENTAL HEALTH
APPLICATION for CERTIFICATION

☐ INITIAL CERTIFICATION
☐ CERTIFICATION OF ADDITIONAL SERVICES

NAME OF PROVIDER SEEKING CERTIFICATION:_____

ADDRESS: _____

CONTACT PERSON: _____ PHONE NUMBER:_____DATE: ___/___/___

CERTIFICATION REQUESTED: ☐ DMH/D ☐ DMH/C ☐ DMH/G ☐ DMH/H ☐DMH/O

PLEASE COMPLETE THE FOLLOWING **IN DETAIL.** ATTACH PAGES AS NECESSARY.

I. IDENTIFY THE SERVICE(S) FOR WHICH CERTIFICATION IS REQUESTED. *(REFER TO PROGRAM TITLES IN **PARTS IV-X** OF THESE STANDARDS.)*

_____
_____
_____

II. DESCRIBE THE SERVICE(S)

A. Describe the program design and days/hours of operation in detail. Attach pages as necessary.

_____
_____
_____

B. Location (Include a floor plan.)
Physical Address: ☐ **Same** ☐ **Different** from above. If different, provide address at which program is to be located.

_____
_____

Do other DMH-certified programs exist at address listed above? ☐ **Yes** ☐ **No** If yes, provide Certificate #s for each program:

_____
_____

C. Staffing, by position and title (Attach job description(s) including minimum qualifications.)

_____
_____
_____

D. Description of individuals to be served in each service (such as, diagnostic categories, ages, number to be served.) Programs providing a service to more than one population (i.e., mental health, mental retardation, etc.) must clearly indicate the number to be served for each population. For child/adolescent mental health Day Treatment, also include individual case record #s, justification of need, duration and intensity of symptoms for each individual in relation to Part VI, Section I.

_____
_____
_____

E. Geographic area to be served (state, county, city, etc.) For child/adolescent mental health Day Treatment, also provide school district to be served.

_____
_____

F. Attach any permits, inspections, etc. required to operate the facility. (See Part III, Section A, Standard 70.0)

G. Provide information on the legal status of the applicant organization (private non-profit, private for profit, public, etc.). Attach a copy of the applicable section of the *Mississippi Code of 1972, Annotated*, or a copy of other legal documents that clearly establish the applicant's status including at least the Mississippi Charter of Incorporation. The sponsoring organization must be incorporated in Mississippi and have established an office (physical location) within the boundaries of Mississippi. Also, a copy of the applicant's organizational by-laws must be attached.

H. ~~If applying for certification under the DMH/C option, describe how Case Management for individuals with Mental Retardation/Developmental Disabilities will be made available. (See Form I of this section.)~~

_____

NAME OF EXECUTIVE OFFICER OF APPLICANT ORGANIZATION (TYPED)

_____ _____

SIGNATURE OF EXECUTIVE OFFICER **DATE**

Mail completed application, attachments, and any required fees to the appropriate BMH/BMR Division of Accreditation and Licensure.

BUREAU OF MENTAL HEALTH
DIVISION OF ACCREDITATION & LICENSURE
1101 ROBERT E. LEE BUILDING
239 NORTH LAMAR STREET
JACKSON, MISSISSIPPI 39201
(601) 359-1288

OR

BUREAU OF MENTAL RETARDATION
DIVISION OF ACCREDITATION & LICENSURE
1101 ROBERT E. LEE BUILDING
239 NORTH LAMAR STREET
JACKSON, MISSISSIPPI 39201
(601) 359-1288

DIVISION OF ACCREDITATION & LICENSURE
1101 ROBERT E. LEE BUILDING
239 NORTH LAMAR STREET
JACKSON, MISSISSIPPI 39201
(601) 359-1288
FAX NUMBER

FOR DMH USE ONLY

REVIEWED (DIVISION)						
APPROVED (INITIAL)						
COMMITTEE APPROVAL						

~~Contract/Interagency Agreement~~

~~The following agreement form for Mental Retardation/ Developmental Disabilities Services must be used to address Section H of the Application for Certification Form. The form must be filled out completely, signed by the appropriate personnel, and submitted with the application.~~

FORM I

AGREEMENT FOR THE PROVISION OF
MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES SERVICES

For the purpose of providing mental retardation/developmental disabilities services, it is hereby agreed by to provide Case Management Services in the following counties for

	CASE MANAGEMENT

It is further agreed by the provider program that the above named service will be provided in accordance with the Minimum Standards for Community Mental Health/Mental Retardation Services as established by the Mississippi Department of Mental Health.

The period of this contract is from _____ to _____.

If through any cause, either of the parties shall fail to fulfill in the proper manner its obligations under this contract or either party shall violate any stipulations of this agreement, either party has the right to terminate this agreement by giving thirty (30) days written notice by certified mail to the other party and the Mississippi Department of Mental Health, Bureau of Mental Retardation, Division of Accreditation and Licensure, 1101 Robert E. Lee Bldg., Jackson, MS, 39201.

_____ Typed name of Contracting Agency Official

_____ Signature of Contracting Agency Official

_____ Address

_____

_____ Date

_____ Typed Name of Contractor Agency Official

_____ Signature of Contractor Agency Official

_____ Address

_____

_____ Date

SECTION E - CERTIFICATION PROCESS

I. Initial Certification/Certification of New or Additional Services:

A. To receive certification by the Mississippi Department of Mental Health, providers must be in compliance with Part I - Procedures for Certification, Part II - Organization and Management, Part III - Human Services, and, all applicable minimum standards of Parts IV-X, as appropriate. (See Section A - Certification Options.)

B. An Application for Certification (as described in Section D - Application Guidelines) must be submitted and found acceptable by the appropriate Bureau before a Certification Visit can occur.

C. If the application for certification (as described in Section D - Application Guidelines) is found acceptable, the Department of Mental Health Bureau of Mental Health and/or Bureau of Mental Retardation Divisions of Accreditation and Licensure will contact the applicant for initial/additional (new) service certification and schedule an on-site Certification Visit by a Certification Review Team from the Department to review, at a minimum, the following:

Note: The Department may request a copy of any of the following for review prior to the initial certification visit.

1. Policies and procedures manual(s);

2. List of staff, including qualifications;

3. Record of staff training provided by the applicant provider to date;

4. Description of program site (including current floor plan, if applicable);

5. For applicants requesting initial certification or certification for additional services in children's mental health day treatment programs only: a minimum of four case records justifying the need for and appropriateness of day treatment services for those youth, as specified in Part VI, Section I.

D. If the applicant meets all applicable minimum standards for the services for which certification is requested, the applicant will be issued a Certificate of Operation within thirty (30) days of the initial on-site

Certification Visit. This certificate will be valid for one to two years as listed on the certificate.

E. If applicants requesting certification for participation in the Home and Community Based Services Mental Retardation/Developmental Disabilities (HCBS) Waiver program (to be designated as DMH/H upon certification) meet the requirements for DMH/H certification, the Department of Mental Health will notify the Division of Medicaid to send the applicant a Mississippi Medicaid Provider Application to receive a provider number to render the HCBS Waiver service(s) for which certification is being granted.

Once the applicant receives a Mississippi Medicaid provider number, the Certificate of Operation will be issued by the Department of Mental Health.

Note: The provider will not be able to claim reimbursement for HCBS Waiver services before they are assigned a Mississippi Medicaid provider number specifically for HCBS Waiver services and receive a Certificate of Operation.

F. The Certification Review Team may conduct an exit interview with the provider staff at the end of the visit, providing an overview of the visit, strengths, and any anticipated deficiencies. Within 10 days following the last day of the on-site Certification Visit, the Department will send the provider a written Review Report regarding the program's compliance with minimum standards, including any findings of deficiencies in implementation of the minimum standards.

G. If the Department Certification Review Team finds the provider not to be in compliance with all minimum standards applicable to the program(s) for which certification was requested, the following will occur:

1. If deficiencies are found in implementation of any Critical standard posing a danger to the health, safety and/or welfare of the individuals served as determined by the Department, a Certificate of Operation will not be issued.

2. If deficiencies are found in implementation of Category 1 Standards dealing with service outcomes as determined by the Department, the provider may be provided the option to submit a Plan of Correction (as described in Part I, Section E, III) to address the deficiencies in order to proceed with the certification process. Programs will be notified by the Department of Mental Health of the time line for correction of Category 1 deficiencies.

3. If deficiencies are found in implementation of Category 2 Standard(s), as determined by the Department, the provider may be provided the option to submit a Plan of Correction (as described in Part I, Section E, III) to address the deficiencies in order to proceed with the certification process. Programs will be notified by the Department of Mental Health of the time line for correction of Category 2 deficiencies.

H. Providers requesting initial certification or certification for additional services cannot receive reimbursement for program(s) addressed in the Plan of Correction until the Plan of Correction is approved and a valid Certificate of Operation is issued. If it is found on a subsequent visit that the Plan of Correction was not implemented in accordance with time lines specified in the Plan, Department of Mental Health funding will cease and will be recouped. Also, any funding source(s) requiring Department certification will be notified of the provider's status of noncompliance with minimum standards. (See III. Plan of Correction that follows in this section for more information.)

II. Recertification

A. Providers with a valid Certificate of Operation from the Department of Mental Health for existing programs do not have to submit another Application for Certification form to initiate the process for recertification of those programs covered by the valid certificate. However, as noted in Part I, Section D, if certification is requested for new services or additional programs, an Application for Certification for additional services must be submitted.

B. A Certification Visit of the program for which recertification is required must occur before any services operated under the certificate can continue beyond the ending date on the valid Certificate. The Certificate of Operation will include beginning and ending dates for which certification is valid.

C. Before the end of the period for which the current Certificate of Operation is valid (one or two years), the Department Certification Review Team will make a certification visit to determine the provider's compliance with all minimum standards applicable to the program(s) for which recertification is required.

D. The Certification Review Team may hold an exit interview with the provider staff at the end of the visit, providing an overview of the visit, strengths, and any anticipated deficiencies. Within 10 days following the

last day of the on-site Certification Visit, the Department will send the provider a written Review Report regarding their compliance with minimum standards including any deficiencies found.

E. If the Certification Review Team finds the provider to be in compliance with all minimum standards applicable to the program(s) for which recertification is required, the Department will issue a Certificate of Operation, valid for one or two years, in accordance with individual certification designation requirements. (See Part I, Section A – Certification Options.)

F. If the Certification Review Team finds the provider not to be in compliance with all minimum standards applicable to the program(s) for which recertification was required, the following will occur:

1. If deficiencies are found in implementation of any Critical standard posing a danger to the health, safety and/or welfare of the individuals served, the provider will not be recertified, and current certification may be revoked from the date of notification by the Department. Certificate(s) of Operation for applicable program(s) must be returned to the Department of Mental Health. No services requiring Department certification can be provided or reimbursed from and after the date the certificate is revoked.

   Before the provider can again offer the services for which certification was revoked, the provider must successfully complete requirements under the preceding Section E – Certification Process , I. Initial Certification/Certification of New or Additional Services.

2. If deficiencies are found in implementation of Category 1 Standards dealing with service outcomes, as determined by the Department, the provider must submit a Plan of Correction (as described in Part I, Section E) to address the deficiencies in order to proceed with the recertification process. Programs will be notified by the Department of Mental Health of the time line for correction of Category 1 deficiencies.

3. If deficiencies are found in implementation of Category 2 standards, as determined by the Department, the provider must submit a Plan of Correction (as described in Part I, Section E) to address the deficiencies in order to proceed with the recertification process. Programs will be notified by the Department of Mental Health of the time line for correction of Category 2 deficiencies.

4. For DMH/H providers, if discrepancies are found regarding the amount of service provided and the amount of service billed, the Certificate of Operation may be revoked, depending on the severity of the discrepancies.

III. Plan of Correction

A. As referenced previously in this section, if the Certification Review Team finds a provider not to be in compliance with all minimum standards applicable to the program(s) for which certification was requested, the provider must submit a written, detailed Plan of Correction for all deficiencies to the appropriate Bureau Chief within a time limit established by the Department, as specified in the review report (approximately 10 days).

B. The written Plan of Correction must:

1. Provide a detailed description of how the provider will correct each deficiency noted in the Review Report;

2. Provide a target date for completion of correction(s) of each deficiency within the time frame noted in the Review Report by the Department of Mental Health; and

3. Be submitted and signed by the provider's Executive Officer and/or Governing Board representative.

Note: Challenges to the validity of minimum standards will not be accepted as Plans of Correction.

C. Correction of deficiencies in Category 1 Standards must be completed within the time period specified by the Department of Mental Health in the approved Plan of Correction, not to exceed 45 days from the date on the Review Report.

D. Correction of deficiencies in Category 2 Standards must be completed within the time period specified in the approved Plan of Correction, not to exceed 90 days from the date on the Review Report.

E. The provider will be notified of the Department's decision regarding approval or disapproval of the Plan of Correction within 10 days of its receipt by the Department.

F. If the Plan of Correction is approved, certification of the provider will be approved, with maintenance of certification contingent upon implementation of the Plan of Correction, and a Certificate of Operation will be issued for the appropriate program(s).

G. If the Plan of Correction is not approved, the provider will receive a written report from the Department specifying the areas not approved and requiring the submission of a second Plan of Correction within 10 days of the Department's notice of disapproval of the first Plan of Correction.

H. The provider will be notified of the Department's decision regarding approval or disapproval of the second Plan of Correction within 10 days of the Department's receipt of the Plan.

I. If the second Plan of Correction is approved, certification will be issued, with maintenance of certification contingent upon implementation of the Plan of Correction. A Certificate of Operation will be issued for the appropriate program(s).

J. If the second Plan of Correction is not approved, the provider will not receive certification by the Department of Mental Health for applicable program areas. Funding from the Department of Mental Health will cease for applicable service areas from a date specified by the DMH in its notification of the disapproval of the second Plan of Correction.

If certification is denied or revoked, the Department of Mental Health may also notify other funding sources, as appropriate, that certification has been denied or revoked.

K. Appeal of the disapproval of the second Plan of Correction must be in accordance with Part I, Section G - Appeal Procedures.

L. The Department of Mental Health will conduct a Follow-up Visit to determine the provider's implementation of the approved Plan of Correction. This Follow-up Visit will occur after the Department of Mental Health approved date for correction of deficiencies in the approved Plan of Correction. The Follow-Up Visit will be unannounced.

1. If the provider has implemented the approved Plan of Correction, certification status will be maintained.

2. If the provider has not implemented the approved Plan of Correction, certification and funding will be discontinued for

applicable program(s) as of the date of notification by the Department.

3. If certification is revoked, funds will be recouped for the period of time during which the Plan of Correction was not implemented, and the applicable Certificate(s) of Operation must be returned to the Department of Mental Health.

M. Providers denied certification or recertification by the Department of Mental Health may reapply for certification in accordance with Section D – Application Guidelines. Providers may apply for certification/recertification only twice in a 12-month period.

N. Citing of the same Category 1/or critical standard(s) on which the program was found to be deficient in the previous certification visit or on any subsequent visit during the certification period can result in the decertification of that service, since in effect, the implementation of the Plan of Correction has not been continued. Funding will then be discontinued, and the program will be required to re-apply for certification according to the guidelines in Section D – Application Guidelines.

O. For programs that do not receive funds through the Department of Mental Health but are certified by the Department of Mental Health, certification will be revoked if it is found that there is failure to comply with the requirements of the current Minimum Standards for Community Mental Health/Mental Retardation Services, including failure to implement approved Plan(s) of Correction. The Department may send written notification of decertification of the program to other funding sources of the program, as appropriate. Also, the provider will be required to return the Certificate(s) of Operation to the Department of Mental Health.

P. Appeal of decertification based on failure to implement approved Plans of Correction, including continuing deficiencies and other failure to comply with Minimum Standards, must be in accordance with Section G – Appeal Procedures.

IV. Ongoing or Unresolved Fiscal or Programmatic Audits

~~If it is found during the fiscal or program review process that a repayment of funds is required and this repayment has not been made within a year of notice of request for repayment, the provider cannot be certified/recertified for the service for which funds are owed. For any provider that has an ongoing and/or unresolved fiscal or programmatic audit, the Department will not certify or fund additional services for that provider, except as initiated by the Department of Mental Health.~~

I.E.1. All services, programs and sites of service delivery (i.e. satellite offices, supervised living programs, and residential programs) must be certified prior to delivery of services and remain certified in order to continue service provision.

I.E.2. Certification is for a period of three (3) years. During the three (3) year period, the DMH will review all certified providers/programs at intervals deemed necessary by DMH. During the three (3) year certification period, providers will be required to complete a DMH-approved self assessment identifying areas of concerns and a plan to address these areas.

I.E.3. Criteria for programmatic certification includes:

f. Provision of applicable required services in all required locations for desired certification option;

g. Adherence to DMH standards, guidelines, contracts, memoranda of understanding, and memoranda of agreement;

h. Fiscal compliance with DMH fiscal management standards and practices;

i. Evidence of fiscal compliance/good standing with external (other than DMH) funding sources; and

j. Compliance with ethical practices/codes of conduct of professional licensing entities related to provision of services.

I.E.4. Initial Application/Certification of New or Additional Services includes the following:

i. An application for certification must be submitted to the Division of Accreditation and Licensure and found acceptable by DMH Review Committee before an on-site visit can occur.

j. If application is found acceptable, the Division of Accreditation and Licensure will contact the applicant and schedule an on-site visit.

k. Prior to the on-site visit, DMH may conduct a desk review of the following information:

(1) Policies and Procedures manual
(2) Staffing plan, including qualifications
(3) Record of staff training
(4) Description of program site (inclusive of floor plan)
(5) For applicants requesting certification of Children/Youth Day Tx programs, applicants must submit the Individual Service Plan for all children/youth participating in the program. DMH must be able to identify the individual responsible for diagnosis and certification of treatment.

l. In addition to a satisfactory on-site certification visit, applicants must be found to be in compliance with all DMH criteria for certification.

m. If an applicant is found to be in compliance with all DMH criteria for certification and on-site visit, the applicant will be issued a Certificate of Operation within thirty (30) calendar days of completion of the on-site visit.

n. Certificates of Operation are valid for three (3) years. Prior to the end of the three year certification period, the DMH will conduct recertification.

o. Providers/agencies requesting initial certification or certification of additional services cannot seek reimbursement for the service/program until there is a valid Certificate of Operation.

p. For DMH/H providers, DMH will notify DOM of certification status. The applicant/provider will be responsible for applying for a DOM provider number in order to render and claim reimbursement for ID/DD waiver services.

i. DMH/H providers will not be able to claim reimbursement for ID/DD Waiver services before they are assigned a Mississippi Medicaid provider number specifically for ID/DD Waiver services and receive a DMH Certificate of Operation.

DMH Review and Written Reports of Findings

I.E.5. Should deficiencies be found during the on-site visit and/or DMH desk review, the Division of Accreditation and Licensure will issue a written report of findings within ten (10) calendar days of the last day of the on-site visit to the Executive Director of the agency seeking certification.

c. The DMH Written Report of Findings will inform the provider that there is a determination of noncompliance with requirements for certification. The provider is informed that termination of certification will be effective within ninety (90) calendar days from the last day of the on-site visit (whether or not the provider chose to participate in an exit interview with DMH staff). The termination date will be included in the written report.

d. Prior to termination, the provider has the opportunity to achieve compliance with certification requirements.

Plan of Compliance

I.E.6. If found to be in noncompliance with criteria for certification, the Executive Director of the agency must submit a plan of compliance to the Division of Accreditation and Licensure within ten (10) days from the date of the DMH written report.

e. Challenges to the validity of the written report of findings (including specific deficiencies) will not be considered acceptable.

f. If the plan of compliance is found to be acceptable, DMH will notify the agency within ten (10) days of the date of the plan of compliance. A follow-up visit will be scheduled within sixty (60) days from the last day of the on-site visit to determine compliance or that an acceptable level of progress has been achieved.

g. If the plan of compliance and follow-up visit is satisfactory, DMH will notify the provider/agency in writing that the plan of compliance and follow-up visit were satisfactory and the termination process will cease.

h. If the plan of compliance is not acceptable, DMH will notify the agency within ten (10) days of the date of the plan of compliance that the plan is not acceptable. The termination of certification process will continue.

Termination of Certification

I.E.7. If no acceptable plan of compliance is achieved, termination of certification will be effective ninety (90) calendar days from the last day of the on-site visit (as identified in the DMH Written Report of Findings).

a. DMH will notify applicable funding sources of the possible termination within fifteen (15) days prior to the termination date.

b. On the identified termination date, termination takes effect if compliance is not achieved.

Criteria for DMH Administrative Suspension or Termination of Certification

I.E.8. A determination that the certification status may be reduced, suspended or revoked shall be made upon any of the following criteria:

h. Failure to comply with DMH Minimum Standards.

i. Failure to comply with guidelines, contracts, memoranda of understanding, and memoranda of agreement.

j. Failure to comply with DMH fiscal requirements.

k. Defrauding an individual receiving services, individual that may potentially receive services and/or third party payer sources.

l. Endangerment of the safety, health, and or the physical or mental well-being of an individual served by the agency/program.

m. Inappropriate and/or unethical conduct by program staff or its governing authority.

n. Any other just cause as identified by the MS State Board of Mental Health/ DMH Executive Director.

I.E.9. Determinations to initiate proceedings for DMH Administrative Suspension or Termination of Certification are made by the DMH Executive Director or his designee.

c. The DMH Administrative Suspension or Termination of Certification may follow the same timelines as established for compliance/noncompliance with programmatic certification criteria unless otherwise directed by the DMH Executive Director and/or MS State Board of Mental Health. Any changes in timelines will be made in writing to the provider/agency involved.

d. In cases of an emergency related to care and treatment of individuals, fiscal or budgetary emergencies or deficiencies, or other emergency situations as determined at the discretion of DMH, a certification may be changed or revoked immediately, with or without prior notice to the provider.

Recertification

I.E.10. Providers with a valid Certificate of Operation from the DMH for existing programs do not have to submit another Application for Certification form to initiate the process for recertification of those programs covered by the valid certificate.

I.E.11. A Certification Visit of the program for which recertification is required must occur before any services operated under the certificate can continue beyond the ending date on the valid Certificate. The Certificate of Operation will include beginning and ending dates for which certification is valid.

I.E.12. Before the end of the period for which the current Certificate of Operation is valid (three years), the Department Certification Review Team will make a certification visit (which may include desk review and on-site visit) to determine the provider's compliance with criteria for certification.

I.E.13. The process for recertification is the same process as outlined in Standards I.E.5. through I.E.7.

I.E.14. Ongoing or Unresolved Fiscal or Programmatic Audits

If it is found during the fiscal or program review process that a repayment of funds is required and this repayment has not been made within a year of notice of request for repayment, the provider cannot be certified/recertified for the service for which funds are owed. For any provider that has an ongoing and/or unresolved fiscal or programmatic audit, the Department will not certify or fund additional services for that provider, except as initiated by the DMH.

SECTION F - PEER REVIEW

I.F. All DMH funded/certified programs are subject to a DMH-approved peer review/quality assurance evaluation process that assures that appropriate assessment, diagnosis and treatment are provided according to established professional criteria and guidelines. Additionally, this process assures that services are provided in accordance with basic, generally-accepted standards of ethical and professional behavior.

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. 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.

Members of the Peer Review team include consumers of services designed to meet the needs of individuals with mental illness, intellectual or developmental disabilities, and alcohol or drug abuse disorders. Family members, mental health professionals and interested stakeholders also comprise the peer review team. Team members obtain information from peers and program staff about satisfaction with services, review programs, and dialogue with mental health administrators. The team provides feed back to providers and local advisory councils.

SECTION G - APPEAL PROCEDURES

I.G.1. Any provider applying for and/or holding certification by the Department of Mental Health may appeal the following decisions and/or penalties:

A. Disapproval by the Department of Mental Health of the second Plan of Correction;

B Any financial penalty(ies) associated with noncompliance with ~~minimum~~ operational standards or audit findings;

C. Denial of request for waiver of ~~minimum~~ a operational standard ~~(s)(as referenced under Section H - Process for Requesting a Waiver); and~~

D. ~~Decertification based on failure to implement approved plans of correction.~~ Termination of Certification.

I.G.2. Appeal procedures are as follows:

1. All appeals must be initiated by filing a written notice of appeal by certified mail in an envelope clearly marked Notice of Appeal with the ~~appropriate Bureau Chief(s)~~ DMH Executive Director and a copy to the Mississippi Department of Mental Health attorney within ~~15~~ 10 days from the date of the final notification by the Department of Mental Health of the decision(s) being appealed (described above).

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

3. The written notice of appeal must contain:

   a. 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) by the Department of Mental Health under appeal; and

   b. A statement of the relief requested.

4. ~~The appropriate Bureau Chief(s) will conduct the first level of review of the written appeal.~~ The Executive Director will forward the appeal with the appropriate Bureau Director. The Bureau Director will conduct the first level of review.

5. If the Bureau ~~Chief(s)~~ Director determines that the appeal merits the relief requested without any additional information by Bureau ~~Chief(s)~~ Director and/or DMH attorney, the appellant will be notified that the relief requested is granted within ~~15~~ 10 days of receipt of the written appeal.

6. If the Bureau ~~Chief(s)~~ Director determines that additional information is needed to make a decision or recommendation, additional written documentation from the appellant may be requested within ~~15~~ 10 days of receipt of the appeal. The Bureau ~~Chief(s)~~ Director will specify a time line by which the additional information must be received.

7. Within ~~15~~ 10 days of the time set by the Bureau ~~Chief~~ Director for his/her receipt of the additional information requested (described in #6 above), the Bureau ~~Chief(s)~~ Director will:

   a. Determine that the appeal merits the relief requested and notify the appellant that the relief requested is granted; or

   b. 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.

8. Within 10 days of receipt of a recommendation for denial of an appeal from the Bureau ~~Chief(s)~~ Director (as described in 7.b. 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.

9. Time lines for review of appeals by the Bureau ~~Chief(s)~~ Director and Executive Director may be extended for good cause as determined by the Department of Mental Health.

10. If the Executive Director concurs with the findings of the Bureau ~~Chiefs~~ Director to deny the appeal, the appellant may file a written request by certified mail in an envelope clearly marked Notice of Appeal with the Executive Director's office, 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)~~ five (5) days after the date of the notice of the Executive Director's decision to deny the appeal.

11. The written notice of appeal described in #10 above must have as its first line of text Notice of Appeal in bold faced type (specifically stating that the notice is in fact an appeal).

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

    a. 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

    b. A statement of the relief requested.

13. 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.

14. 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.

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

SECTION H - PROCESS FOR REQUESTING A WAIVER

I.H.1. 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 Department, in accordance with the following procedures:

1. To request a waiver of a specific standard, the provider's Executive Officer must make a written request to the Division of Accreditation and Licensure ~~in the appropriate Bureau.~~ The request must:

    a. List the standard(s) for which a waiver is being requested;

    b. Describe, in detail, all operational systems, personnel, etc., which function to meet the intent or objective of the standard;

    c. Provide justification that the waiver of the standard, if approved, will not diminish the quality of service;

    d. Designate individual program location(s) for which the waiver is requested; and;

    e. Specify the length of time for which the waiver is requested.

2. ~~The Bureau Chief(s) and/or other Department of Mental Health~~ The DMH Review Committee and other personnel, as appropriate, will review the waiver request, and the ~~Bureau Chief(s)~~ Committee will approve or deny the request.

3. The Executive Officer of the program provider making the request will be notified of the decision within ~~31~~ 30 days of receipt of the request.

4. Appeal of the denial of requests for waivers must be in accordance with Part I, Section G - Appeal Procedures.

I.H.2. Any waivers granted under previous revisions of DMH standards are void as of January 1, 2011. Waivers should be resubmitted to DMH for review and consideration.

I.H.3. Waivers granted by DMH serve only to waive a DMH standard.

SECTION I - CERTIFICATE OF OPERATION

I.I.1. ~~I.~~ Limitations of the Certificate

A. 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 Mississippi ~~Department of Mental Health~~ DMH.

B. A Certificate of Operation is not transferable.

C. 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).

d. Site capacities must not exceed the number identified on the Certificate of Operation.

~~D.~~e. Certification for any established period, service or program is contingent upon the program's continual compliance with current ~~Minimum Standards for Community Mental Health/Mental Retardation Services~~ Operational Standards for Mental Health, Intellectual/Developmental Disabilities and/or Substance Abuse Community Service Providers as established by the ~~Department of Mental Health~~ DMH.

I.I.2. ~~II.~~ Posting of Certificates

The original Certificate of Operation must be posted in each of the certified sites for public view. Certificates are specific to a site/building/location/name and capacities and may not be transferred to new locations. If changes are made that affect information on the certificate, the certificate must be returned to the Division of Accreditation and Licensure ~~in the appropriate Bureau~~. If the changes do not alter certification status, a new certificate will be issued. Certificates for closed programs must be returned to the ~~Department of Mental Health~~ DMH within 15 days of the last day individuals were served by the provider in the program.

I.I.3. If the provider is certified for programs at multiple sites, the Department will issue:

A. A Certificate of Operation listing all the programs and services for which the provider is certified. This general certificate does not imply that all services listed can be or are provided at this primary location or at other locations (see below). This certificate must be displayed in an area clearly visible to individuals being served by the provider in the primary or regional administrative or service building; and,

B. A Certificate of Operation for individual programs at different locations. These certificates must be displayed in an area clearly visible to people being served in the individual facility or area in which the program is implemented. These certificates apply to, and must be posted at, the physical address indicated on each certificate.

For example, a provider of services in multiple counties will receive a Certificate of Operation listing all the various types of programs or services provided (outpatient mental health services, children's mental health day treatment services, alcohol/drug abuse prevention services, etc.), as well as a separate Certificate of Operation for display in each program location for which the provider is certified.

SECTION J - CHANGES TO BE REPORTED TO ~~THE STATE DEPARTMENT OF MENTAL HEALTH~~ DMH

I.J. Following certification, changes affecting the governing and/or operation of programs must be reported in writing to the ~~appropriate Bureau/~~Division of Accreditation and Licensure in the Mississippi ~~Department of Mental Health~~ DMH. 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.

I.J.1. Examples of the significant changes that must be reported 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; and/or,

9. Change(s) in the name(s) of the program(s) certified by the DMH.

I.J.2. 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.

SECTION K - TECHNICAL ASSISTANCE BY DEPARTMENT OF MENTAL HEALTH STAFF

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

SECTION L - ACCESS TO FACILITIES, PROGRAMS, SERVICES AND INFORMATION

I.L.1. Representatives of the ~~Department of Mental Health~~ DMH 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.

I.L.2. Department of Mental Health program and fiscal staff have authority to interview personnel individually concerning matters regarding programmatic and fiscal compliance, including follow-up on matters reported to the Department's Office of Constituency Services. Failure to comply with requests for such interviews will result in termination of the audit/review and possible discontinuance of funding.

I.L.3. When programs are visited by Peer Review/Quality Assurance Evaluation Team members, statements concerning confidentiality must be signed by all members on the team who are not ~~Department of Mental Health~~ DMH Employees ~~(see Standard 100.6)~~. Visits to sites may be unannounced. ~~If a provider is in doubt about the identity of personnel visiting their programs, staff should request to see proper identification.~~

~~PART II~~

~~ORGANIZATION AND MANAGEMENT~~

PART II

ORGANIZATION AND MANAGEMENT

All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part.

SECTION A - GOVERNING AUTHORITY

II.A.1. ~~10.0~~ The provider program must have documented evidence of the source of its governing authority.

II.A.2. ~~10.1~~ The governing authorities of all providers must have bylaws and/or policies that:

a. 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;

b. Show documentation of the adoption of a schedule of meetings and quorum requirements;

c. Require at least quarterly meetings;

d. Provide assurance that the governing authority does not consist of employees or immediate family members (i.e. spouses and children) of employees;

~~d.~~ e. Provide assurances that meetings of the governing authority are open to the public and include procedures for notifying the public of meetings;

~~e~~. f. Assure that governing authority members do not receive a per diem that exceeds the state limit.

~~f~~. g. Require minutes of meetings, which are to include, but not be limited to:

(1) the date of the meeting;

(2) names of members and other participants/visitors attending;

(3) topics and issues discussed, motions, seconds and votes; and,

(4) public comment.

II.A.3. ~~10.2~~ The governing authority of all providers must have written documentation of the following:

a. Appointment of a full-time Executive Director who has a minimum of a Master's degree in a mental health/mental retardation or related field with a minimum of three (3) years administrative experience in ~~mental health related programs and, after July 1, 2002, is eligible to apply for DMH mental health administrator credentialing.~~ programs related to mental health, intellectual/developmental disabilities, or substance abuse services and/or programs.

b. The Executive Director's authority and responsibility for the management of the program and for implementing the policies of the governing authority.

c. Completion of an annual evaluation of the Executive Director that is available for review.

d. Designation of staff positions to have authority and responsibility for all program operations in the absence of the Executive Director.

e. Establishment of an organizational structure as evidenced by an organizational chart.

II.A.4. ~~10.3~~ The governing authority of all providers must review and approve at least annually the following, and document such review in the governing authority minutes:

a. Annual budget;

b. Written affiliation agreements;

c. All changes in the policies and procedures;

d. Annual Operational Plan submitted to the Mississippi Department of Mental Health (Except providers certified under DMH/H);

~~e. Written overall Program Plan for providing services;~~

~~f. Written Program Plan evaluation report.~~

II.A.5. All certified providers must have a formal mechanism 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 the service area for which they receive services.

~~10.4 Providers, except those certified as DMH/H that have specifically received a waiver, must have an individual/family advisory committee to advise the governing authority on matters related to individual/family satisfaction, annual operational plan, performance outcomes, program planning and evaluation, quality assurance/improvement, type and amount of services needed, and other issues/items that the advisory committee chooses to address. The advisory committee must:~~

~~a. Have a membership of at least two-thirds (2/3) family members and individuals served by the provider and one-third (1/3) other interested individuals, with representation commensurate with the relative proportion of the major services they provide (such as adult mental health, alcohol and drug abuse services, child mental health, mental retardation/developmental disabilities, and/or Alzheimer's disease and other dementia).~~

~~b. Meet at least quarterly;~~

~~c. Provide written recommendations to the governing authority at least annually on the above named areas;~~

II.A.6. ~~10.5~~ Regional Commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*, must also maintain written documentation of the following:

a. Central inventory of capital property that will include the owner, current value, and any mortgage on said property;

b. Annual cost report, developed and submitted within guidelines established by the ~~Mississippi Department of Mental Health~~ DMH.

II.A.7. ~~10.6~~ Regional Commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*, must also 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.*

II.A.8. ~~10.7~~ Regional Commissions established under Section 41-19-31 et seq. of the *Mississippi Code of 1972, Annotated*, must also maintain written documentation of the following:

a. 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, mental retardation, 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;

b. Documentation of hazard, casualty or worker's compensation insurance, as well as professional liability insurance;

c. Written approval of the Department of Mental Health 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;

d. Authority of the commission to provide and finance services through various mechanisms and to borrow money from private sources for such, if needed;

e. 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 Mississippi Department of Mental Health of such contract/arrangement before its initiation and annually thereafter;

f. 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 Mississippi Department of Mental Health of such provision before its initiation and annually thereafter;

g. 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 Mississippi Department of Mental Health of such provision before its initiation and annually thereafter;

h. 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 Mississippi Department of Mental Health, of such action before initiation and annually thereafter;

i. 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*), when such action affects more than one region, written prior approval by the Mississippi Department of Mental Health, of such action before initiation and annually thereafter;

j. 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;

k. Efforts to provide or provision of alternative living arrangements for persons with serious mental illness, including, but not limited to, group homes for individuals with serious mental illness.

SECTION B- POLICIES AND PROCEDURES MANUAL

II.B.1. ~~10.8*~~ There must be developed a written Policies and Procedures Manual(s) which addresses all sections and standards in ~~Part II - Organization and Management, Part III - Human Services~~ Parts II-VII and for all services provided under Parts ~~IV~~ VIII through ~~X~~ XVIII. These written policies and procedures must give details for implementation and documentation of the ~~Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services~~ DMH Operational Standards for MH/IDD/SA Community 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 program.

II.B.2. ~~10.9~~ The policies and procedures manual must:

a. Be reviewed at least annually by the governing authority, as documented in the governing authority meeting minutes;

b. Be readily accessible to all staff, with a copy at each service delivery location;

c. Describe how the manual is made available to the public.

II.B.3. ~~11.0~~ 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.

SECTION C- PLANNING

II.C.1. ~~11.1~~ An Annual Operational Plan must be submitted to the Mississippi Department of Mental Health for approval or disapproval by the date specified by DMH. (Section 41-4-7 (f) of the *Mississippi Code of 1972, Annotated*)

II.C.2. ~~11.2~~ The Annual Operational Plan required in ~~11.1~~ Standard II.C.1. must address, at a minimum, the Regional Community Mental Health/Mental Retardation Commission's or other community service provider's status and plans to comply with:

a. ~~Minimum~~ Operational standards for community services established by the Mississippi ~~Department of Mental Health~~ DMH for certification, including current status regarding compliance with ~~DMH Minimum Standards for Community Mental Health/Mental Retardation Services~~ DMH Operational Standards for MH/IDD/SA Community Providers , based on the most recent certification visit by the Mississippi ~~Department of Mental Health~~. DMH.

b. Minimum required services for certification established by ~~the Mississippi Department of Mental Health~~ DMH for certification:

For Regional Community Mental Health/~~Mental Retardation~~ Intellectual Disability Commissions:

(1) ~~Current quantitative service levels in relation to established minimum service components and minimum quantitative service level targets established by the Mississippi Department of Mental Health (refer to Part I, Section C);~~

(2) Description of funding for each minimum service component at the current service level by major funding source (federal, state, local);

(3) Targeted quantitative service levels planned for each minimum service component for the applicable fiscal year for which the Annual Operational Plan is being submitted;

Targeted areas to be served;

(4) Brief narrative substantiating targeted quantitative service levels, clearly noting any increase, decrease, or maintenance in current service levels.

~~(5) Projected funding by major funding source (federal, state, local) for implementation of each minimum service component at targeted quantitative service levels.~~

For Other Community Service Providers:

(6) Current quantitative performance levels in relation to service component(s) targeted by the grant/contract and specific outcome measures for the service component(s) approved by the Mississippi Department of Mental Health in the signed Program Grant Award and/or Purchase of Service Contract ~~(Refer to Part I, Section C);~~

(7) Funding for service components at current performance levels by major funding source (federal, state, local);

(8) Targeted performance level on outcome measure planned for each service component for the applicable fiscal year for which the Annual Operational Plan is being submitted;

(9) Brief narrative substantiating targeted performance level on outcome measure, clearly noting any increase, decrease or maintenance in current performance levels;

(10) Projected funding by major funding source (federal, state, local) for implementation of each service component at targeted performance levels or outcome measure levels.

II.C.3. ~~NOTE:~~ The ~~Mississippi Department of Mental Health~~ DMH will approve or disapprove the Annual Operational Plan of the Regional Mental Health/~~Mental Retardation~~ Intellectual Disability Commission and Other Community Service Providers based on minimum required standards and minimum required services established by the Department. The Department will notify the Commission/other community service provider in writing of approval/disapproval of the Annual Operational Plan. The Commission/other community service provider will receive a written Report of Review of the Annual Operational Plan, to include approval/disapproval status. (Section 41-4-7 (f) of the *Mississippi Code of 1972, Annotated*)

II.C.4. If the Annual Operational Plan is disapproved, the DMH will include in the Report of Review of the Annual Operational Plan notification of the disapproval and any follow-up action required, such as, but not limited to, a summary of deficiencies in the Plan and actions required for the commission/other community service provider to address these deficiencies within the probationary period. The time line(s) for any probationary period (beginning and ending dates) will be specified in the Report of Review of the Annual Operational Plan, but will not exceed six months in accordance with Section 41-4-7 (f) of the *Mississippi Code of 1972, Annotated*.

II.C.5. The governing authority of the certified provider must document in the governing authority minutes their review of the DMH Report of Review of Annual Operational Plan.

~~11.3 The governing authority must document in the governing authority minutes their review of the Mississippi Department of Mental Health Report of Review of Annual Operational Plan provided in response to review of the Annual Operational Plan submitted by the Regional Commission or other community service provider.~~

~~NOTE: If the Annual Operational Plan is disapproved, the Mississippi Department of Mental Health will include in the Report of Review of the Annual Operational Plan notification of the disapproval and any follow-up~~

~~action required, such as, but not limited to, a summary of deficiencies in the Plan and actions required, for the commission/other community service provider to address these deficiencies within the probationary period. The time line(s) for any probationary period (beginning and ending dates) will be specified in the Report of Review of the Annual Operational Plan, but will not exceed six months in accordance with Section 41-4-7 (f) of the *Mississippi Code of 1972, Annotated*.~~

II.C.6. ~~11.4~~ Within ten days after the ending date of the probationary period, the Regional Commission or other community service provider must provide a written status report concerning their status on implementation of actions required by the ~~Mississippi Department of Mental Health~~ DMH in the Mississippi Mental Health Report of Review of Annual Operational Plan.

II.C.7. ~~NOTE~~: If after the ending date of the probationary period, the Department determines, based on review of the status report or other information, that a Regional Commission/other community service provider still does not meet the ~~minimum~~ operational standards and minimum required services, certification may be denied or revoked.

II.C.8. ~~11.5~~ The Regional Commissions and other community service providers must submit the Annual Operational Plan and any related follow-up reports on forms (or in the format) provided or approved by the Mississippi Department of Mental Health.

~~11.6 In addition to complying with the appropriate areas of the current Minimum Standards for Community Mental Health/Mental Retardation Services, a program or provider must comply with special guidelines and/or regulations issued by the Mississippi Department of Mental Health 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.~~

~~11.7 In addition to applicable minimum standards, programs funded by the Mississippi Department of Mental Health must comply with any additional specifications set forth in individual program grants/contracts.~~

PART III

FISCAL MANAGEMENT

III.FM. All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part.

Compliance with Operational Standards in this section will be reviewed by the DMH Fiscal Auditors.

III.FM.1. The program must prepare and maintain annually a formal, written, program-oriented budget of expected revenues and expenditures for the program that must:

a. Categorize revenues for the program by source;

b. Categorize expenses by the types of services or program components provided, and/or by grant funding;

c. Account for federal funds separately in accordance with the Single Audit Act of 1984.

III.FM.2. The fiscal management system of the program must include a fee policy that:

a. Maintains a current written schedule of rate, charge, and discount policies;

c. Is immediately accessible to individuals served by the program;

c. For residential programs, includes the development, and result in documentation, of a written financial agreement with each individual or parent/legal guardian (of individuals under 18 years of age) entering the program that, at a minimum:

1. 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;

2. Is prepared prior to or at the time of admission and signed by the individual/parent/legal guardian and provided in two (2) or more

copies, one (1) copy given to the individual/parent/legal guardian, and one (1) copy placed on file in the individual's record; and

3. Does not relieve the provider of the residential program of the responsibility for the protection of the person and personal property of the individual admitted to the residential program for care.

III.FM.3. The fiscal management system of the program must:

a. 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 are not exceeded;

b. Provide monthly financial reports to the program provider's governing authority and Executive Director as documented in Board minutes;

c. 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;

d. Provide evidence that all generated income accounts are included in required fiscal audits.

III.FM.4. Audited financial statements must be prepared annually by an independent Certified Public Accountant or, for state agency operated programs, the State Auditor's Office. These financial statements:

c. Must include all foundations, component units, and/or related organizations;

d. 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 Administrative to prevent interruptions in grant funding;

e. 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.);

f. Include a management letter describing the financial operation of the program.

III.FM.5. Programs must develop a cost accounting system that defines and determines the cost of single units of service.

III.FM.6. Regional Community Mental Health Centers must prepare and submit to DMH an annual Unit Cost Report using forms and instructions promulgated by DMH. These reports are due within nine (9) months from the end of the agency's fiscal year.

III.FM.7. The program must develop and adhere to purchasing policies and procedures that ensure:

a. 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;

b. 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);

c. The agency maintains adequate documentation to support all purchasing transactions (e.g. requisitions, bids, purchase orders, receiving reports, invoices, canceled checks and contracts);

d. The agency 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.

e. The agency 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;

g. 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;

g. Ensure that all insurance proceeds or proceeds from the sale of grant inventory be returned to the program for which it was initially purchased; and

h. Property and equipment ledgers are periodically reconciled to general ledger accounts.

III.FM.8. The program must develop an accounting system to document grant, match, and funds of individuals receiving services that:

a. 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;

b. 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;

c. 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;

d. 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;

e. 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;

f. 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.

III.FM.9. Bonding is required for all personnel who handle program funds to cover risks associated with employee dishonesty or theft.

III.FM.10. Unless otherwise provided by law, the agency must have insurance that includes liability, fire, theft, disaster, professional liability and workman's compensation.

III.FM.11. All agencies must have policies that include/address the following:

a. Non-discrimination based on ability to pay, race, sex, age, creed, national origin or disability;

b. A sliding fee scale;

c. A method of obtaining a signed statement from the individual receiving services indicating that the individual's personal information provided is accurate;

III.FM.12. 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.

III.FM.13. Accounting records must be maintained on generated income from work contracts that detail dollar amounts and fund utilization as specified in Standard III.FM.3.d.

III.FM.14. The program must maintain evidence of prior written authorization from the DMH/Bureau of Intellectual and 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:

a. Enhancing or enriching the program; and

c. Not being used as part of the required match.

HUMAN RESOURCES

All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part and subsequent Sections A-D.

SECTION ~~B~~ A- PERSONNEL POLICIES

VI.A.1. ~~20.0~~ The program must have written personnel policies and procedures that at a minimum:

a. 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;

b. Prohibit pre-employment inquiries about the nature of an applicant's disability which does not affect their ability to perform the job.

VI.A.2. ~~20.1~~ The written personnel policies must describe personnel procedures addressing the following areas:

a. Wage and salary administration;

b. Employee benefits;

c. Working hours;

d. Vacation and sick leave (includes maternity leave);

e. Annual job performance evaluations. Job performance evaluations must be in writing, and there must be documented evidence that evaluations are reviewed with the employee;

f. Suspension or dismissal of an employee, including the employee appeal process;

g. Private practice by program employees.

VI.A.3. ~~20.2~~ Staff must be designated, with documentation in their respective job description(s), to implement and/or coordinate personnel policies and procedures and to:

a. Maintain personnel records;

b. Disseminate employment information to program staff;

c. Supervise the processing of employment forms.

SECTION B- PERSONNEL RECORDS

VI.B.1. ~~20.3*~~ 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 current Mississippi license or certification for all licensed or certified personnel;

c. A copy of college transcripts, high school diploma, and/or appropriate documents to verify that educational requirements of the job description are met;

d. Wage and salary information, including all changes;

e. A copy of the annual performance evaluation;

f. Documentation of contact with at least two of the listed references, one of which must be a former employer and/or professional reference;

g. A written job description along with documentation of annual review by employee and supervisor, including necessary updates as appropriate. The job description shall include, at a minimum:

(1) Job title;

(2) Responsibilities of the job;

(3) Skills, knowledge, training/education and experience required for the job.

h. A copy of a valid driver's license for all designated drivers;

i. 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 Executive Director of the organization.

j. 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 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 ~~the effective date of these standards~~ July 1, 2002 must be fingerprinted.

~~20.4 There must be documentation of staff members' initial review of the program's Policies and Procedures Manual within thirty (30) days of hire, along with documentation of staff members' review of any subsequent changes.~~

SECTION C- QUALIFICATIONS

VI.C.1. ~~20.5~~ Unless otherwise specified herein, all staff employed on and after the effective date of these standards must meet the minimum qualifications listed below. ~~For staff members who do not yet meet minimum educational requirements in this section~~ and ~~for whom a period of time is allowed for them to obtain the required degree, evidence of their enrollment each semester in course work toward that degree must be maintained in the individual staff's personnel file.~~ In order for a ~~mental health~~ service provider to receive funds and/or certification for services provided from the ~~Department of Mental Health~~ DMH or other approved source, the provider must maintain documentation that:

~~a. Psychiatric services, including such services as medication evaluation and monitoring, the initial evaluation, prescribing of medications, and regular/periodic monitoring by a psychiatrist or physician 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) 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;~~

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

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

~~d. Psycho-educational evaluation services are provided by a psychometrist certified by the Mississippi Department of Education;~~

~~e. Therapy or Counseling services are provided by an individual with at least a Master's degree and (1) a professional license (ex: Licensed Professional Counselor, licensed physician, licensed (Master's level) social worker), or who (2) is a DMH Credentialed Mental Health Therapist or DMH Credentialed Mental Retardation Therapist (as appropriate to the population being served); staff providing therapy or counseling services mainly to individuals with serious mental illness or children with serious emotional disturbance must have a CMHT or LCMHT, while staff providing therapy or counseling services mainly to individuals with mental retardation must have a CMRT or LCMRT. Requirements for Alcohol/Drug Abuse Therapists/Counselors, Chemical Dependency Unit, Residential Program Counseling staff, and all aftercare workers are described separately in sections of this standard that follow;~~

~~f. Case management services, other than School Based or Mental Illness Management Services (MIMS), including HCBS Waiver Support Coordination services, are provided by an individual with at least a Bachelor's Degree in a Mental Health, Mental Retardation, or related field. HCBS Waiver Support Coordination can also be provided by a Registered Nurse;~~

a. ~~g.~~ ~~Coordinator(s)/Supervisor(s)~~ Director(s) with overall responsibility for a service or service area(s) (such as Community Services Director or ~~Case Management Supervisor~~Director of Case Management Services, Director of HCBS Waiver Support Coordination, ~~Coordinator of~~ Program Director for Adult and Children's Partial Hospitalization, Day Treatment, Therapeutic Foster Care, Therapeutic Group Homes, Mental Illness

Management Services (MIMS) ~~Clubhouse, Work Activity/ Supported Employment, Alternative Living, Day Habilitation, etc.)~~ must have at least a Master's degree in mental health~~, mental retardation,~~ or intellectual/developmental disabilities, or a related field and (1) a professional license ~~(example: Licensed Professional Counselor, Licensed Physician, Licensed (Masters Level) Social Worker,~~ or who (2) is a DMH credentialed Mental Health Therapist or DMH credentialed ~~Mental Retardation~~ Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served and/or supervised). ~~Staff providing supervision of therapy or counseling services mainly to individuals with serious mental illness or children with serious emotional disturbance must have a LCMHT, while staff providing supervision of therapy or counseling mainly to individuals with mental retardation must have a LCMRT. Requirements for Alcohol and Drug Abuse Prevention Coordinators and requirements for Alcohol/Drug Abuse Coordinators are described below;~~

b. In addition to the requirements outlined in Standard VI.C.1.a., Directors of Therapeutic 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.

c. ~~h.~~ Supervisor(s) with predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services, for such areas as Work Activity, Community Living (with the exception of Therapeutic Foster Care and Therapeutic Group Homes), Day Habilitation, Clubhouse Programs, etc., must have at least a Bachelor's degree in a mental health, ~~Mental Retardation~~ intellectual disabilities, or a related field, and be under the supervision of an individual with a Master's degree in a mental health, ~~Mental Retardation~~ intellectual/developmental disabilities, or a related field. ~~Requirements for Directors of Alcohol/Drug Abuse Residential Programs for adults and the requirements for Directors of Inpatient Chemical Dependency Units and Adolescent Residential Treatment Programs are described below;~~

d. Psychiatric services, including such services as 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) 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;

(3) A psychiatric/mental health nurse practitioner licensed by the Mississippi Board of Nursing.

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

e. 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 Law and Rules and Regulations. Nursing services are physician prescribed nursing services necessary for the support and habilitation/rehabilitation of the recipient;

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

k. Psycho-educational evaluation services are provided by a psychometrist certified by the Mississippi Department of Education;

l. Therapy or Counseling services are provided by an individual with at least a Master's degree and (1) a professional license (i.e. LMSW, LPC, LMFT) or who (2) is a DMH Certified Mental Health Therapist or DMH Certified Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served).

m. In addition to the requirements outlined in Standard VI.C.1.h, the mental health therapist in Therapeutic 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.

j. All Day Treatment Specialists providing direct 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 (i.e. LMSW, LPC, LMFT) or (2) hold DMH credential as a Mental Health Therapist or a Intellectual/Developmental Disabilities Therapist, as appropriate to the population served.

k. Case management services, other than School Based or MIMS, 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 DMH Case Management Credential. ID/DD Waiver Support Coordination can also be provided by a Registered Nurse;

l. School Based Services (Case Management Services) and MIMS are provided by an individual with at least a Master's degree and (1) a professional license (i.e. LMSW, LPC, LMFT) or who (2) is a DMH Credentialed Mental Health Therapist or DMH Certified Intellectual/Developmental Disabilities Therapist, as appropriate to the population being served.

m. 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.

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

r. All staff providing Peer Support Services (i.e. Peer Specialist) must possess a high school degree or GED equivalent, self identify as a current or former consumer of mental health services, demonstrate a minimum of 12 months in self-directed recovery in the last year, and successfully complete the DMH approved Certified Peer Specialist training and certification exam.

s. Support staff such as Aide, House Parent, House Manager, Secretary, Office Clerk, Bookkeeper, Cook, Direct Care Worker, Direct Support Professionals, Work Trainer, Production Assistant, staff providing Individual Therapeutic Support Services, Day Treatment Assistants, support staff in Psychosocial Rehabilitation (clubhouse), Elderly Psychosocial Rehabilitation, and Day Support Programs, Day Habilitation worker, home and community support services staff, job coaches, etc., must have at least a high school education or a GED and be at least twenty-one (21) years old. Staff providing Individual Therapeutic Support Services must also complete certification approved by the DMH.

~~i. 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 Law and Rules and Regulations. Nursing services are physician prescribed nursing services necessary for the support and habilitation/rehabilitation of the recipient. Examples of nursing activities include assessment of extrapyramidal symptoms, education of the recipient and family about illness, and injection of psychotropic medication prescribed by a physician;~~

~~j. Teachers and Education Specialists have a Master's degree or a Bachelor's degree in Special Education, as required, with training in a Mental Health, Mental Retardation, or a related field, and possess certification by the Mississippi Department of Education appropriate to the service area to which they are assigned.~~

~~k. Each of the above listed positions that provide direct supervision of any HCBS Waiver service(s) as described in Part IV of these standards for any of the positions listed in the following subsections must also meet the following definition of a Qualified Mental Retardation Professional (QMRP):~~

~~A QMRP must have at least one year of experience working directly with persons with mental retardation or other developmental disabilities; and be one of the following:~~

~~(1) A licensed physician;~~

~~(2) A registered nurse;~~

(3) An individual who holds at least a Master's degree in psychology from an accredited program, who has specialized training or one year of experience as listed above working directly with persons with mental retardation;

(4) An educator with a Bachelor's degree in education from an accredited program, who has specialized training or one year experience as above working directly with persons with mental retardation;

(5) A social worker with a Bachelor's degree from an accredited program, or with a Bachelor's degree in a field other than social work and at least three years social work experience under the supervision of a qualified social worker, and who has specialized training or one year of experience as stated above working directly with persons with mental retardation;

(6) A registered physical or registered occupational therapist who has specialized training or one year of experience in treating persons with mental retardation;

(7) A therapeutic recreation specialist who is a graduate of an accredited program and who has one year of experience in working with persons with mental retardation; or

(8) A rehabilitation counselor who is certified by the Committee on Rehabilitation Counselor Certification and who has specialized training or one year of experience as listed above working directly with persons with mental retardation.

l. Support staff such as Aide, House Parent, House Manager, Secretary, Office Clerk, Bookkeeper, Cook, Direct Care Worker, Work Trainer, Production Assistant, staff providing Individual Therapeutic Support Services, support staff in Psychosocial Rehabilitation (clubhouse), Elderly Psychosocial Rehabilitation, and Day Support Programs, Day Habilitation worker, etc., must have at least a high school education or a GED and be at least eighteen (18) years old. Support staff employed in Alcohol and Drug Abuse residential treatment programs who are in recovery must also have a minimum of six (6) months of sobriety. Staff providing Individual Therapeutic Support Services must also

~~complete certification approved by the DMH. Additionally, the qualifications listed below are required for the following staff providing HCBS Waiver Services (as described in Part IV of these standards):~~

~~(1) Attendants must have successfully completed the Mississippi Federal/State Nurse Aide Training and Competency Evaluation Program and be on the registry for same or have successfully completed a training course in attendant care that is approved by the Department of Mental Health or be approved in writing by the Director of the Bureau of Mental Retardation to provide service for a particular individual. In-Home Companion Respite Providers must also have a valid driver's license.~~

~~(2) In-Home Companion Respite Providers must have successfully completed the Mississippi Federal/State Nurse Aide Training and Competency Evaluation Program and be on the registry for same or have successfully completed a training course in attendant care that is approved by the Department of Mental Health or be approved in writing by the Director of the Bureau of Mental Retardation to provide service for a particular individual. In-Home Companion Respite Providers must also have a valid driver's license.~~

~~(3) Community Respite Workers must have documentation of successful completion of training in the Department of Mental Health Direct Care Worker Training program or an equivalent training program approved by the Department of Mental Health and have a valid driver's license.~~

~~(4) Residential Habilitation Worker(s) must have documentation of successful completion of training in the Department of Mental Health Direct Care Worker Training program or an equivalent training program approved by the Department of Mental Health and have a valid driver's license.~~

~~(5) Day Habilitation Worker(s) must have documentation of successful completion of training in the Department of Mental Health Direct Care Worker Training program or an equivalent training program approved by the Department of Mental Health. They must also possess a valid driver's license.~~

~~(6) Supported Employment/Prevocational Worker(s) must have documentation of successful completion of training in the Department of Mental Health Direct Care Worker Training program or an equivalent training program approved by the Department of Mental Health. They must also possess a valid driver's license.~~

~~(7) Behavioral support interventionist(s) must:~~

~~(a) hold a current license to practice medicine or psychology, verifiable by their respective state licensing entities; or,~~

~~(b) be a currently licensed clinical social worker; or,~~

~~(c) hold a Mississippi Department of Mental Health credential; and,~~

~~(d) have four years of documented experience developing and implementing behavioral support/intervention programs for persons with mental retardation.~~

~~m. Specialists such as Audiologists, Speech-Language Pathologists, Occupational Therapists, Dietitians, Physical Therapists, etc., must meet the educational requirements of and be licensed by their respective licensing authority in Mississippi;~~

VI.C.2. The following standards are only applicable to providers certified under the DMH/H option.

a. Behavioral Support Interventionist(s) who conduct evaluations and develop behavior support plans must:

(1) hold a current license to practice medicine or psychology, verifiable by their respective state licensing entities; or,

(2) be a currently Licensed Certified Social Worker; or,

(3) have a degree in a related field such as special education or psychology;

(4) and have four (4) years of documented experience developing and implementing behavior support/intervention programs for individuals with IDD.

b. Staff who provide/implement direct behavior support/intervention services must:

(1) hold a current license to practice medicine or psychology, verifiable by their respective state licensing entities; or,

(2) be a currently licensed clinical social worker; or,

(3) have a degree in a related field such as special education or psychology;

(4) and have two (2) years of documented experience developing and implementing behavior support/intervention programs for individuals with IDD.

VI.C.3. Unless otherwise specified herein, all staff employed on and after the effective date of these standards must meet the minimum qualifications listed below for providers of Substance Abuse Prevention and Rehabilitation Services.

~~n.~~ a. Directors of Alcohol and Drug residential programs for adults ~~hired after the effective date of these standards~~ must have at least a:

(1) Master's degree in mental health/~~mental retardation~~ intellectual/developmental disabilities or a related behavioral health field and two (2) years of experience in the field of substance addiction/abuse treatment/prevention. For individuals who are in recovery from chemical dependency, a minimum of one (1) year ~~sobriety is also required; or~~ of non-abusive use of alcohol and/or drugs or;

(2) Bachelor's degree in mental health/~~mental retardation~~ intellectual/developmental disabilities or a related behavioral health field and two (2) years of experience in the field of substance addiction/abuse treatment/ prevention. They must also complete an alcohol/drug treatment certification program approved by DMH within 30 months of the date of employment. For

individuals who are in recovery from chemical dependency, a minimum of one (1) year ~~sobriety is also required;~~ of non-abusive use of alcohol and/or drugs.

~~o.~~ b. Directors of Inpatient Chemical Dependency Unit, and Adolescent Residential Treatment Programs, hired after the effective date of these standards must have at least a Master's degree in mental health ~~/mental retardation~~ intellectual/developmental disabilities or a related behavioral health field, and at least two (2) years of experience in treatment/prevention of substance addiction/abuse. If the person is recovering from chemical dependency, a minimum of one (1) year ~~sobriety is required;~~ of non-abusive use of alcohol and/or drugs.

c. Support staff employed in Alcohol and Drug Abuse Residential Programs who are in recovery must also have a minimum of one (1) year of non-abusive use of alcohol and/or drugs.

~~p.~~ d. Alcohol and Drug Abuse Prevention ~~Coordinators hired after the effective date of these~~ standards Specialists must have at least a Bachelor's degree. For individuals who are in recovery from chemical dependency, a minimum of one (1) year ~~sobriety is also required;~~ of non-abusive use of alcohol and/or drugs is required.

~~q.~~ e. Alcohol and Drug Abuse Coordinators ~~hired after the effective date of these standards~~ must have at least a Master's degree in mental health/~~mental retardation~~ 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. For individuals who are in recovery from chemical dependency, a minimum of one (1) year ~~sobriety is also required;~~ of non-abusive use of alcohol and/or drugs is required.

~~r.~~ f. Alcohol and Drug Abuse Outpatient Therapists/Counselors, must have at least a Master's degree in mental health ~~/mental retardation~~ intellectual/developmental disabilities or a related behavioral health field. Intensive Outpatient Programs must consist of a director who meets the requirements listed above and at least one back-up or support staff

member. All back-up/support IOP staff must have at least a Bachelor's degree in one of the same educational fields mentioned above. For individuals who are in recovery from chemical dependency, a minimum of six (6) months ~~sobriety is also required. (See also t. that follows.)~~ of non-abusive use of alcohol and/or drugs is required. *(See also j. that follows.)*

i. Directors of Intensive Outpatient Programs (IOP) must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs.

j. All back up/support IOP Staff must have at least a Bachelor's degree in mental health or intellectual/developmental disabilities or a related behavioral health field. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of non-abusive use of alcohol and/or drugs.

~~s.~~ i. ~~For individuals hired after the effective date of these standards,~~ Alcohol and Drug Abuse Chemical Dependency Unit and Residential Program counseling staff and all aftercare workers must have at least a high school diploma or equivalency. These individuals must also successfully complete an alcohol and drug treatment certification program approved by DMH within thirty (30) months of the date of employment. For individuals who are in recovery from chemical dependency, a minimum of ~~six (6) months sobriety is also required. (See also t. that follows.)~~ one (1) year of non-abusive use of alcohol and/or drugs is required. *(See also j. that follows.)*

~~t.~~ j. Providers certified as DMH/C that provide the following Medicaid-reimbursed services 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) a professional license ~~(ex. Licensed Professional Counselor, licensed physician, Licensed (Master's level) Social Worker)~~, or (2) ~~who is~~ a DMH ~~credentialed~~ Mental Health Therapist credential.~~: individual therapy, family therapy, group therapy, multi-family therapy and treatment plan review.~~ (This requirement also applies to

counseling services provided in alcohol/drug residential treatment programs operated by DMH/C providers and billed to Medicaid.)

~~u. All Day Treatment Specialists providing direct day treatment services for children and youth, employed after the effective date of these standards must have a Master's degree in a mental health or related mental health field and (1) a professional license (ex. Licensed Professional Counselor, Psychologist, Licensed (Master's level) Social Worker or Physician) or (2) hold DMH credential as a Mental Health Therapist or a Mental Retardation Therapist, as appropriate to the population served. Staff providing direct Day Treatment services mainly for children and youth with serious emotional disturbance must have a CMHT or LCMHT, while staff providing direct Day Treatment services mainly to individuals with mental retardation must have A CMRT or LCMRT. Staff employed before that date must obtain a Master's degree in a mental health field and (1) a professional license (ex. Licensed Professional Counselor, Psychologist, Licensed (Master's level) Social Worker, or Physician) or (2) hold DMH credential as a Mental Health Therapist or Mental Retardation Therapist, as appropriate to the population served, before July 1, 2004.~~

~~v. See Part VI (Mental Health Services for Children and Youth) Section B, Residential Services for Children/Youth for qualifications of staff employed or under contract to provide services in therapeutic group homes for youth;~~

~~w. See Part VI (Mental Health Services for Children and Youth) Section B, Residential Services for Children/Youth for qualifications of staff employed or under contract to provide services in therapeutic foster care programs.~~

~~x. School Based Services and Mental Illness Management Services (MIMS) must be provided by an individual with a Master's degree and professional license (ex. Licensed Professional Counselor, Psychologist, Licensed (Master's level) Social Worker or Physician), or (2) hold DMH credential as a Mental Health Therapist or a Mental Retardation Therapist, as appropriate to the population served. Staff providing School Base Services and Mental Illness Management mainly to individuals with serious mental illness and children and youth with serious emotional disturbance must have a CMHT or LCMHT, while staff providing School Based Services and Mental Illness Management Services~~

~~mainly to individuals with mental retardation must have a CMRT or LCMRT.~~

~~20.6 Community Mental Health/Mental Retardation Center providers (certified under the DMH/C option) 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 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 Social Worker with a Master's degree from an accredited school of social work;~~

~~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.~~

~~20.7 Community Mental Health Center providers (certified under the DMH/C option) must employ an individual on a full-time basis to supervise children's mental health services, i.e., with administrative authority and responsibility for children's mental health services after the effective date of these standards. These individuals must have a Master's degree in a mental health or related field and have at least one year of experience in administration or supervision of a mental health or mental health related program/service and is a DMH credentialed therapist, CMHT/LCMHT.~~

~~20.8 If a provider uses volunteers, there must be policies and procedures describing, at a minimum, the following:~~

~~a. The scope and objectives of the volunteer service (role and activities of volunteers);~~

~~b. Supervision of volunteers by staff member in areas to which volunteers are assigned;~~

~~c. Process for recruitment, assignment, and evaluation of volunteers; and,~~

~~d. Implementation of an orientation training program (See also 50.4).~~

VI.C.4. Unless otherwise specified herein, all staff employed on and after the effective date of these standards must meet the minimum qualifications listed below for providers of Programs of Assertive Community Treatment (PACT) for adult mental health services.

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 works on a full-time or part-time basis (as required in Standard XIII.A.6) 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 Specialist: A mental health professional with training and experience in substance abuse 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 specialist. Peer 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 degree and work experience with adults with severe and persistent mental illness or with individuals with similar human-services needs. These para-professionals 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 education or a GED and be at least twenty-one (21) years old.

VI.C.5. Community Mental Health Center providers (certified under the DMH/C option) 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 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;

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.

VI.C.6. Community Mental Health Center providers (certified under the DMH/C option) must employ 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, i.e., with administrative authority and responsibility for children's mental health services.

VI.C.7. Unless otherwise specified herein, all individuals employed on and after the effective date of these standards must meet the 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 twelve (12) months in self-directed recovery.

g. Individuals must provide documentation of successful completion of at least one of the DMH recognized peer programs.

e. Individuals must be a DMH certified Peer/Family Support Specialist under the supervision of a mental health professional.

VI.C.8. If a provider uses volunteers, there must be policies and procedures describing, at a minimum, the following:

a. The scope and objectives of the volunteer service (role and activities of volunteers);

b. Supervision of volunteers by staff member in areas to which volunteers are assigned;

c. Process for recruitment, assignment, and evaluation of volunteers; and,

e. Implementation of an orientation training program (See also Section D below).

SECTION C – FISCAL MANAGEMENT

Compliance with minimum standards in this section will be reviewed by the Department of Mental Health auditors.

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

a. Categorize revenues for the program by source;

b. Categorize expenses by the types of services or program components provided, and/or by grant funding;

c. Account for federal funds separately in accordance with the Single Audit Act of 1984.

30.1 The fiscal management system must include a fee policy that:

a. Maintains a current written schedule of rate, charge, and discount policies;

b. Is immediately accessible to individuals served by the program;

30.2 The fiscal management system must:

a. 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 are not exceeded;

b. Provide monthly financial reports to the program provider's governing authority and Executive Director as documented in Board minutes;

c. 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;

d. Provide evidence that all generated income accounts are included in required fiscal audits. Proper documentation and evidence of prior DMH approval of these expenditures must be maintained.

Program generated income reports and related expenditure reports must be submitted monthly with the program's cash request.

30.3 Audited financial statements must be prepared annually by an independent certified public accountant or, for state agency operated programs, the State Auditor's Office. Audited financial statements must:

a. Be presented to the agency's governing authority and to the Department of Mental Health upon completion;

b. Be prepared in accordance with the Single Audit Act of 1984, (detailed in Section VII of the DMH Service Providers Manual). This statement must be completed within nine (9) months of the close of the facility's fiscal year for facilities which expend $300,000 or more in Federal financial assistance. Written requests for extensions must be made to the DMH Administrative Bureau Chief to prevent interruptions in DMH funding;

c. Include a management letter describing the financial operation of the program; and,

d. Include any related information.

30.4 Regional Community Mental Health Centers must prepare and submit to the Department of Mental Health an annual Unit Cost Report using forms and instructions promulgated by the Department of Mental Health.

30.5 The program must develop and implement purchasing policies and procedures that:

a. Insure that purchasing, storage, and distribution of assets are executed in accordance with federal and state regulations;

b. Insure that the agency's purchases are properly documented, by utilizing and maintaining evidence of requisitions, bids from suppliers, purchase orders, receiving reports, vendor invoices, canceled checks and contract agreements.

30.6 The program must develop policies and procedures with regard to depreciable assets that:

a. Provide for detailed property and equipment ledgers that are periodically reconciled to general ledger control accounts;

b. Insure proper documentation of additions to and deletions from fixed asset ledgers (Programs must refer to the DMH Service Providers Manual to note the proper use of DMH-101-01 when reporting fixed asset information to DMH);

c. Insure that the provider has written approval from the Department of Mental Health and/or the County Board of Supervisors, depending on the original source of funding, before disposal of real and personal property paid for with state and/or county appropriated funds.

30.7 Policies and procedures for proper accounting and administrative internal controls must be implemented. The program must:

a. Utilize an accounting system consisting of a general ledger, cash disbursements journal, payroll journal, cash receipts journal, or journals serving the same purpose, which are posted at least monthly;

b. Provide adequate sources of documentation for all expenditures such as invoices and contract agreements with any allocation method on file;

c. Insure that any check issued by a program have two (2) signatures such as Board Chairman, Executive Director, Business Manager or Chief Fiscal Officer (combination of any two);

d. Insure Federal funds are expended in accordance with the applicable Federal cost circular and the Uniform Administrative Requirements for Grants and Cooperative Agreements to State and Local Governments (The Common Rule);

30.8 All personnel handling funds of the program must be bonded.

30.9 The program must develop and implement a cost accounting system that defines and determines the cost of single units of service.

31.0 Unless otherwise provided by law, the agency must have insurance that includes liability, fire, theft, and disaster.

31.1 All programs must have policies that include/address the following:

a. Non-discrimination based on ability to pay, race, sex, age, creed, national origin, or disability;

b. A sliding fee scale;

c. A method of obtaining a signed statement from the individual receiving services indicating that individual's personal information provided is accurate.

31.2 All programs must have supportive documentation for personnel such as time and attendance records.

31.3 At any time a Regional Commission, and/or other related organization whatever it may be, accumulates surplus funds in excess of one-half (2) of its annual operating budget, the entity must submit a plan to the Department of Mental Health 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 group homes for individuals with mental illness, mental retardation, substance abusers, children, or other mental health/mental retardation services approved by DMH.

SECTION D - PROGRAM PLANNING AND EVALUATION

40.0 The program must have a written overall Program Plan for providing the specific services for which it is certified. The Program Plan must be reviewed and approved annually by the governing authority, as documented in the governing authority meeting minutes. The Program Plan must include at a minimum:

a. Measurable goals and objectives for each service element;

b. Strategies for accomplishing the stated goals and objectives;

40.1 At least annually, the provider must evaluate and report on the implementation of the approved Program Plan by:

a. Evaluating the actual performance of the provider in each service against stated goals and objectives contained in the Program Plan;

b. Providing utilization data on service(s) addressed in the plan, as required by the Department of Mental Health, including data specified by individual Department of Mental Health Divisions.

40.2 A written report of the annual evaluation of the Program Plan must be prepared and distributed annually to the governing authority, appropriate staff members and funding sources. Furthermore,

a. Annual review and approval of the Program Plan evaluation report by the governing authority must be documented in governing authority minutes;

b. The Program Plan's evaluation report must be submitted to the Department of Mental Health within thirty (30) days of the close of the provider's fiscal year.

40.3 The program must have a Quality Improvement Plan implemented for all service areas which addresses, at a minimum, the following:

a. Reduction or increase of the use of institutional care according to data collected;

b. Trends (increase/decrease) in the utilization of services;

c. Quality of services delivered to individuals living in the community.

d. Evaluation of the effectiveness and appropriateness of service activities by peer staff. A peer staff evaluation committee must be established to make a random review of service(s) provided. A report of the peer staff evaluation activities must be distributed annually to the governing authority, appropriate staff members, and the Department of Mental Health. The report must include at a minimum, a review of each service's outcomes, basis for other reviews, date of review(s), listing of persons involved and their designation as internal or external staff/family/other, major findings, and the program's improvement plan;

e. Individual and family satisfaction with the availability, accessibility, and appropriateness of services. For Department of Mental Health certified programs, each individual receiving services must be given an opportunity to participate in an annual Satisfaction Survey to express their level of satisfaction with the provider's or individual program's services. The program must

submit a report to the Department of Mental Health that summarizes the responses received along with the information specified in Standard 40.2;

40.4 A written report of the results, changes, or proposed changes, based on review of the evaluation of the Quality Improvement Plan activities by peer staff committee must be prepared and distributed annually to the governing authority, appropriate staff members and funding sources. This report must be submitted to the Department of Mental Health along with the report required in Standard 40.2.

SECTION E D- TRAINING AND STAFF DEVELOPMENT

All Service Providers

50.0 All staff are required to participate in orientations, staff development opportunities, and other meetings as required by the Department of Mental Health.

50.1 Documentation of training of individual staff must be included in individual training/personnel records and must include:

a. Date of training;

b. Names of staff participating;

c. Topic(s) covered;

d. Name of presenter(s) and qualifications;

e. Contact hours (actual time spent in training).

50.2* Training on the following must be conducted and/or documented prior to service delivery for all newly hired staff and direct services volunteers and annually thereafter for all program staff. Persons who are trained in the medical field (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 DMH approved program within the time frame required may also be excluded:

a. First aid and life safety including handling of emergencies such as choking, seizures, etc.;

b. Preventing, recognizing and reporting abuse/neglect, including provisions of the Vulnerable Adults Act, and the Mississippi Child Abuse Law;

c. Handling of accidents and roadside emergencies (programs transporting only);

d. Crisis intervention including appropriate use of seclusion and restraint and applicable state and federal regulations pertaining to such;

e. Rights of individuals served by the program;

f. Confidentiality of information pertaining to individuals served by the program, including appropriate state and federal regulations governing confidentiality, particularly in addressing requests for such information;

g. Fire safety and disaster preparedness to include:

(1) Use of alarm systems,;

(2) Notification of authorities who would be needed/require contact in an emergency;

(3) Actions to be taken in case of fire/disaster, and;

(4) Use of fire extinguisher(s).

h. Cardiopulmonary Resuscitation (CPR) training (every two 2 years), including Child and Infant Cardiopulmonary Resuscitation (CPR) for individuals expected to work with children or assigned to children's program areas;

i. Records Management for HCBS Waiver Program staff only;

j. Recognizing and reporting serious incidents, including completion of reports; and,

k. Universal precautions for containing the spread of contaminants.

50.3* Training of newly hired staff and direct services volunteers on the following must be completed within thirty (30) days of hire and annually thereafter:

a. Department of Mental Health Minimum Standards for Community Mental Health/Mental Retardation Services;

b. Behavior management;

c. Family issues (sensitivity, family education, and family inclusiveness);

d. Specialized Training in responding to mental health emergencies for all persons involved in the provision of emergency services;

e. Records Management;

f. Cultural diversity/sensitivity;

g. Program policies and procedures.

50.4 Individual programs must establish and address minimum training requirements for non-direct service volunteers.

50.5 All providers must provide training in areas not otherwise specified in these standards, when required in writing by the Department of Mental Health.

Mental Retardation/Developmental Disabilities Programs

51.0* Prior to the delivery of services, each staff person providing services to individuals with mental retardation/developmental disabilities must also have documentation of training in working with individuals who have mental retardation/developmental disabilities (or provide documentation of at least one year of experience working with people who have mental retardation/ developmental disabilities).

51.1* BMR programs must provide and document quarterly staff training relating specifically to their service areas, that will improve the quality of services/ supports provided by staff to individuals with mental retardation/ developmental disabilities. At least one of the quality training sessions must include information on community inclusion/integration of the individuals with mental retardation/developmental disabilities.

Mental Health Services for Children and Youth

52.0 Within three (3) months of employment, each staff person providing services to children/youth with behavioral/conduct or emotional disorders must be provided or receive training addressing at a minimum, the following topics:

a. Serious emotional disturbance (definition, identification, implications);

b. Ideal mental health service array model for children (as in the current State Plan for Community Mental Health Services);

c. Substance abuse and HIV to include the following areas:

(1) HIV/AIDS;

(a) information including:

(i) modes of transmission;

(ii) Universal Precautions and other preventative measures against contracting/spreading the virus;

(iii) current treatments and how to access them.

(b) administration of the risk assessment;

(c) procedures to follow for individuals indicated to be high risk.

(d) pre- and post-prevention counseling.

(2) Tuberculosis (TB);

(a) information including:

(i) modes of transmission;

(ii) current treatments and how to access them.

(b) administration of the risk assessment;

(c) procedures to follow for individuals indicated to be high risk.

(3) Sexually Transmitted Diseases (STDs);

(a) information including:

(i) modes of transmission;

(ii) precautions to take against contracting these diseases;

(iii) progression of diseases;

(iv) current treatments and how to access them.

d. Availability of other services in community.

52.1 Children's mental health crisis programs must have evidence of implementation of a specialized orientation and in-service training prior to service delivery for all staff working in the program, in addition to the initial training in crisis intervention required in standard 50.2. This training must include at least the following areas specific to effective crisis management:

a. Assessment and diagnosis;

b. Crisis intervention and stabilization;

c. Other topics or skills that relate directly to crisis residential or other specialized crisis services for children and youth;

d. Involuntary commitment procedures and the admission criteria for the state-operated regional psychiatric hospital(s) serving the provider's catchment area.

52.2 Staff providing telephone crisis services must receive specialized training for effective crisis management described in 52.1 a. - d. In addition, they must receive training addressing the following areas:

a. Services offered by the provider operating the telephone crisis service and other services available in the local community for children/youth (including entry criteria for those services); and,

b. Appropriate response and referral as part of the telephone crisis response process.

Alcohol and Drug Abuse Services

53.0 Records must be maintained which indicate training within three (3) months of hire for newly hired staff providing alcohol/drug abuse prevention and treatment services, and annually thereafter in the following areas:

a. HIV/AIDS;

(1) information including:

(a) modes of transmission;

(b) Universal Precautions and other preventative measures against contracting/spreading the virus;

(c) current treatments and how to access them.

(2) administration of the risk assessment;

(3) procedures to follow for individuals indicated to be high risk.

(4) pre- and post-prevention counseling.

b. Tuberculosis (TB);

(1) information including:

(a) modes of transmission;

(b) current treatments and how to access them.

(2) administration of the risk assessment;

(3) procedures to follow for individuals indicated to be high risk.

c. Sexually Transmitted Diseases (STDs);

(1) information including:

(a) modes of transmission;

(b) precautions to take against contracting these diseases;

(c) progression of diseases;

(d) current treatments and how to access them.

53.1 Staff providing services in alcohol and drug treatment programs must receive training annually, addressing the following areas: (This standard does not apply to free-standing programs that provide only prevention services.)

a. Substance abuse and serious mental illness (dual diagnosis);

b. Withdrawal symptoms;

c. Mississippi Implied Consent Law.

53.2 Staff working in an alcohol and/or drug abuse treatment services setting with women must receive annual training in the following areas:

a. Pre-and post-natal care;

b. Preconception counseling/postpartum care;

c. Parenting and family issues.

Mental Health Services for Adults

54.0 Within thirty days of hire, programs must provide and document (as required in standard 50.1) staff development activities that assure staff, including full-time, part-time, temporary personnel, and volunteers, who work in providing services specified below to adults with serious mental illness receive training as approved by the Department of Mental Health, at a minimum, in the following areas:

a. Dual diagnosis (mental illness/substance abuse);

b. Case management orientation;

~~c. Medication use, side effects and issues of compliance (all services);~~

~~d. Family and consumer education, self help and advocacy (all services);~~

~~e. Pre-evaluation screening and civil commitment;~~

~~f. Psychosocial Rehabilitation/Clubhouse Model;~~

~~g. Training in the special needs of elderly persons for staff working with elderly persons;~~

~~h. Specialized training planned and provided for program staff in intensive residential treatment services.~~

~~Adult Day Center Services for Persons with Alzheimer's Disease and Other Dementia~~

~~55.0 The program must provide and document (as required in Standard 50.1and 50.2) staff development activities that assure staff are provided training within the first thirty (30) days of employment and annually thereafter, in services and activities for individuals with Alzheimer's disease and other forms of dementia, addressing at least the following areas:~~

~~a. Purpose and goals of the adult day center;~~

~~b. Needs of adults with dementia;~~

~~c. Causes and manifestation of dementia;~~

~~d. Preventing/managing caregiver stress;~~

~~e. Emergency procedures;~~

~~f. Depression in the elderly;~~

~~g. Grief management.~~

VI.D.1. All new employees and volunteers/interns must attend General Orientation. General orientation must be provided within 30 days of hire/placement, except for direct service providers and direct service interns/volunteers who must receive training prior to contact with individual receiving services.

VI.D.2. General Orientation must consist of a minimum of four (4) hours. At a minimum, General Orientation must address the following areas:

a. Overview of the agency's mission and an overview of the agency policies and procedures

b. Health and Safety

1. Basic First Aid
(a) Choking
(b) Seizures

3. Infection Control
(c) Universal Precautions
(d) Hand-washing

3. Workplace Safety
(e) Fire and Disaster Training
(f) Emergency/Disaster Response
(g) Incident reporting
(h) Reporting of suspected abuse/neglect

c. Rights of Individuals Receiving Services

d. Confidentiality

f. Family and Cultural Issues

(2) Respecting Cultural Differences

f. Basic standards of ethical and professional conduct

1. Drug Free Workplace
2. Sexual Harassment
3. 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*

VI.D.3 Providers must develop an Annual Initial Staff Training Plan specific to each position classification as listed below. Each Initial Staff Training Plan should be based on job responsibilities, program/position requirements, and identified staff needs. The Initial Staff Training Plan should be reviewed annually for changes and/or updates and should be available for review. Position specific training must be provided within 90 days of hire and consist of a minimum of 20 hours of training (medical personnel excluded).

a. The following position classifications must be addressed:

1. Direct service provider (i.e., therapist, case manager, program assistants)
2. Administrative/support staff (i.e., office manager, medical records technician, housekeeper, accounting staff)
3. Interns/Volunteers

VI.D.4. 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 should be reviewed annually for changes and/or updates and should be available for review.

a. The following position classifications and required minimum hours of continuing education must be addressed:

1. Direct service provider (i.e., therapist, case manager, program assistants). A minimum of thirty (30) continuing education hours every two (2) years must be completed by all individuals in this position class.

2. Administrative/support staff (i.e., office manager, medical records technician, housekeeper, accounting staff). A minimum of sixteen (16) continuing education hours every two (2) years must be completed by all individuals in this position class.

3. Medical personnel (i.e., psychiatrist, nurses) – as required by state licensing boards.

Note: Continued licensure/certification relative to an employee's job position may be substituted for the continuing education requirement.

VI.D.5. At a minimum, Initial Staff Training Plans and Continuing Education Plans must address the following areas:

a. Crisis prevention and intervention

b. Abuse reporting

c. Record Keeping

d. DMH Standards relative to expectations of specific program

VI.D.6. All staff is required to participate in orientations, program/position specific training, staff development opportunities, and other meetings as required by their position specification.

VI.D.7. Documentation of training that individual staff has received must be included in individual and/or personnel records. This documentation must include:

a. Name of training

b. Name of person(s) participating in the training

c. Instructor's name and credentials

d. Date of training

e. Length of time spent in training

f. Topics covered

g. Learning objectives

~~SECTION F - GRIEVANCE AND COMPLAINT RESOLUTION~~

~~60.0* There must be written policies and procedures for implementation of a process through which individuals' complaints/grievances can be reported and addressed at the local program/center level. These policies and procedures, minimally, must ensure the following:~~

~~a. That individuals receiving services from the provider have access to a fair and impartial process for reporting and resolving grievances and complaints without retribution;~~

~~b. That individuals are informed and provided a copy of the local procedure for filing a grievance/complaint with the provider and of the procedures and time lines for resolution of complaints/grievances.~~

~~c. That the procedure for resolution of complaints/grievances includes the opportunity to appeal to the executive officer of the program, as well as the governing board of the program.~~

~~d. That the individuals receiving services and/or parent(s)/legal guardian(s) of children are informed of the procedures for reporting/filing a complaint/grievance with the Department of Mental Health, including the availability of the toll-free telephone number for such process, which must be posted prominently in all program areas.~~

~~60.1 There must be written documentation in the record that each individual and/or parent/legal guardian of children 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 program/center.~~

~~60.2 Written procedures, including time lines for reporting and resolving complaints/grievances, must be in compliance with those established by the DMH Office of Constituency Services.~~

PART IV

SERVICE ORGANIZATION

IV.SO. All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part and subsequent Sections A-K, as they pertain to issues related to general service provision.

SECTION A- GENERAL SECTION

IV.A.1. In addition to complying with the appropriate areas of the current DMH Operational Standards for MH/IDD/SA 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.

IV.A.2. In addition to applicable standards, programs funded by the Mississippi DMH must comply with any additional specifications set forth in individual program grants/contracts.

IV.A.3. Providers must submit all reports and data required by the DMH according to the DMH Manual of Uniform Data Standards.

IV.A.4. All certified providers must comply with official revisions to the DMH Operational Standards for MH/IDD/SA Community Service Providers. Official revisions will be issued by the DMH Executive Director to the Executive Directors of all certified providers for incorporation into policies and procedures as directed by DMH. Official revisions to DMH Standards will include, at a minimum:

d. The applicable DMH Standard numbers that are affected by the official revision.

e. An effective date.

f. The signature of the DMH Executive Director.

IV.A.5. In order to receive an official interpretation of a DMH operational standard, entities must submit a request for official interpretation in writing to DMH. DMH will issue an official interpretation in writing in response to the request.

SECTION B – ELIGIBILITY DETERMINATION

IV.B.1. All of the following information must be documented to support an eligibility determination of serious emotional disturbance:

a. Youth has at least one of the eligible diagnosable mental disorders defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) or subsequent editions.

b. Youth with serious emotional disturbance are ages birth up to 21 years.

c. 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.

IV.B.2. All of the following information must be documented to support an eligibility determination of serious mental illness:

a. An individual who meets the criteria for one of the eligible diagnostic categories defined in the most current version of the DSM or subsequent editions.

b. Adults, age 18 and over, with serious mental illness.

c. 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.

SECTION C - ADMISSION TO SERVICES

IV.C.1. Written policies and procedures must address admission to services and must at a minimum:

a. Describe the process for admission or readmission to service(s);

b. Define the criteria for admission or readmission to service(s), including:

(1) Description of the population to be served (age(s), eligibility criteria, any special populations, etc.);

(2) Process for determination of eligibility for service(s) offered by the provider;

(3) Number of residents to be served (providers of community living services only);

(4) Expected results/outcomes; and

(5) Methodology for evaluating expected results/outcomes.

c. Assure equal access to treatment and services for individuals with disabilities who are otherwise eligible;

d. Describe the process or requirements for intake/assessment, including the process for requesting appropriate consent to obtain relevant records from other providers;

e. Describe the procedure for individuals who are ordered to treatment by the court system;

f. Describe written materials provided to individuals upon admission, including materials that may be included in an orientation packet, etc.;

g. Describes the process for informing individuals, youth (if age appropriate) and youth's parent(s)/legal guardian(s) of their rights and responsibilities (including any applicable program rules for residential programs) prior to or at the time of admission;

h. Describe the process to be followed when an individual is found ineligible for admission or readmission to service(s) offered by the provider, including referral to other agencies and follow-up, as appropriate. Such referral(s) and follow-up contacts must be documented;

i. Describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available by the provider; and

j. Assure equal access to treatment and services for HIV-positive persons who are otherwise eligible.

IV.C.2. Providers must have a schedule available to individuals and their families for each service and/or program which includes, at a minimum:

a. Hours of daily operation/hours service and/or program is available;

b. Number of days per year the service and/or program will be provided/is available; and

c. Scheduled dates of closure/unavailability and reasons.

SECTION D - PROGRAM POSTINGS/REQUIRED INFORMATION

IV.D.1. Program rules 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.

IV.D.2. For day and residential programs, emergency telephone numbers must be posted in a conspicuous location near each telephone. Numbers must be included for:

a. Police;

b. Fire;

c. Poison Control Center;

d. Ambulance/Emergency Medical Services (EMS);

IV.D.3. For day and residential programs, the following information should be kept securely at the program/service location:

a. Family member(s) or other contacts (if appropriate and consent is on file) located in a file available to staff; and

b. Case manager and therapist for individuals (if applicable) located in a file available to staff.

SECTION E - SERVICE/PROGRAM DESIGN

IV.E.1. Program activities must be designed to address objectives in Individual Service Plans. Individual Service Plan objectives must reflect individual strengths, needs, and behavioral deficits/excesses 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.

IV.E.2. Services and Programs must be designed to promote and allow independent decision making by the individual and encourage independent living, as appropriate.

IV.E.3. Programs must provide each individual with therapeutic activities and experience in the skills they need to support a successful transition to a more integrated setting, level of service, or level of care.

IV.E.4. The services provided as specified in the Individual Service Plan must be based on the needs and requirements of the individual rather than on the availability of services.

IV.E.5. Prior to discharging someone from a program and/or service because of challenging behavioral issues, the provider must have documentation of development and implementation of a positive behavior support plan. All efforts to keep the individual enrolled in the program and/or service must be documented in the individual's record.

IV.E.6. Providers of outpatient services must describe the range of diagnostic and treatment modalities, as well as family education and support services, to be offered.

IV.E.7. 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:

a. 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.);

b. Includes a written acknowledgment of the school district's receipt and understanding of standards applicable to the children's mental health services.

SECTION F - STAFFING

IV.F.1. 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.

IV.F.2. 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 the licensing entity for which they are licensed.

IV.F.3. If contractual services are provided by a certified provider, or obtained by a certified provider, there must be a current written interagency agreement in place that addresses, at minimum, the following:

a. Roles and responsibilities of both parties identified in the agreement;

b. Procedures for obtaining necessary informed consent, including consent for release and sharing of information; and

c. Assurances that DMH standards will be met by both parties identified in the agreement.

SECTION G- CONFIDENTIALITY

IV.G.1. 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.

IV.G.2. 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. 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:

a. Designated person(s) to distribute records to staff;

b. Specific procedures to assure that records are secure in all locations;

c. 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;

g. 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 continue benefits of the individual. These procedures at a minimum must:

1. 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;

2. Describe the process for releasing information about an individual receiving services without prior written consent, that is, in cases of a medical emergency or upon receipt of a court order;

3. Specify staff authorized to make such release and require that the following is compiled and placed in the record of the individual receiving services:

(a) Individual's name or case number;

(b) Date and time of disclosure;

(c) Information disclosed;

(d) To whom information was disclosed and the reason for disclosure.

(e) The name, credential, and title of the individual disclosing the information.

e. 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;

f. 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;

g. Procedures requiring written consent of the individual receiving services or their guardian, when appropriate, prior to disclosing identifying information to third-party payer;

h. Procedures addressing the release of information regarding individuals receiving alcohol and drug abuse services, in accordance with applicable federal regulations.

IV.G.3. 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.

IV.G.4. All case records must be marked "confidential" or bear a similar cautionary statement.

IV.G.5. The consent to release information form must include:

a. The name of the program which is to make the disclosure;

b. The name or title of the person or organization to which disclosure is to be made;

c. The name of the individual receiving services;

d. The purpose or need for the disclosure;

e. A statement that the consent may be revoked at any time except when action on it has already been taken;

f. The specific condition, event, or date on which the consent will automatically expire, not to exceed twelve months;

g. The extent and nature of information to be disclosed;

h. The date when consent is signed;

i. The signature of the individual receiving services or the signature of a person who is either authorized to give consent or authorized to sign in lieu of the individual;

j. The signature of a witness to the authorization by the individual receiving services to release/obtain information.

IV.G.6. In the case of a community residential program, the program must:

a. Obtain prior written consent from the individual living in the residence or legal representative prior to acknowledging his or her presence in the facility to visitors or to callers;

b. Assure that documentation of such consent is maintained in the case record.

IV.G.7. 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:

a. The purpose of the review;

b. Staff to conduct the review;

c. That reviewer(s) are bound by applicable regulations regarding confidentiality and all others that apply;

d. Reviewer(s) signature(s) and the date signed.

SECTION H- CASE RECORD MANAGEMENT & RECORD KEEPING

IV.H.1. All providers must meet the standards herein and the requirements outlined in the MS DMH Record Guide.

IV.H.2. The program must maintain an indexing or referencing system that allows for locating particular individual case records whenever they are removed from the central file area.

IV.H.3. Records of individuals served by the program must be readily accessible to authorized treatment personnel and there must be written procedures assuring accessibility to records by emergency staff after hours.

IV.H.4. All entries in records of individuals served by the program must be 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. Correction fluid, erasing, or totally marking out original information is not permissible.

IV.H.5. No progress notes in the individual record shall contain the name or other identifiable information of another individual receiving services.

IV.H.6. Individual records must be closed when there has been no contact for a twelve (12) month period. For alcohol and drug services records, the case must be closed when no contacts are recorded for ninety (90) days.

IV.H.7. A record must be maintained for all individuals served by the program and must contain (when applicable) the following information:

a. Face Sheet or Identification Data Form;

b. Intake/Assessment;

c. Comprehensive Individual Service Plan or Service/Activity Plan or Needs Assessment/Aftercare Plan or Plan of Care (for Alzheimer's Day Programs);

d. Case Management Life Domains Assessment/Service Plan;

e. For individuals receiving alcohol and drug abuse services:

(1) Assessment/Educational Activities Documentation Form;

(2). Needs Assessment/Aftercare Plan;

(3) Documentation of detoxification monitoring for primary residential programs;

(4) Documentation of vocational, educational, employment, or related activities for transitional residential program.

f. Documentation of initial staffing and each subsequent staffing/review;

g. Progress Notes and/or Contact Summaries;

h. Medication/Drug Use Profile;

i. Discharge/Termination Summary;

j. Copies of all signed Consent to Treatment, Acknowledgment of Individual's Rights, and Release of Information forms;

k. Any evaluations and diagnostic assessments;

l. Any applicable DMH checklist and certification of eligibility;

m. Consent to release information acknowledging presence of individual served by the program to visitors (if applicable);

p. For individuals who have a legal guardian/conservator appointed by a court of competent jurisdiction, copies of the guardian/conservator order.

q. Copies of any court orders pertaining to outpatient mental health/substance abuse and rehabilitation treatment.

p. For youth served in therapeutic group homes and therapeutic foster care programs:

(1) Documentation that information required in Standard XI.D.1 has been explained/provided in writing to the parent(s), legal guardian(s), and youth prior to or upon admission to the program;

(2) Results of dental examination required in Standard XI.C.5;

(3) Current photograph of the youth;

(4) Educational records and reports;

(5) Copies of any current court order pertaining to the treatment or custody of the youth;

(6) Any permission forms signed by the parent(s)/legal guardian(s) for the youth to participate in specific program activities;

(8) Permission form(s) for staff to provide first aid.

IV.H.8. A licensed physician, with psychiatric training or documented competency in the use of the DSM diagnostic criteria by experience or training, a licensed clinical psychologist, or a psychiatric/mental health nurse practitioner must certify that services are medically/therapeutically necessary as follows for individuals receiving services. (This standard is not applicable for programs for individuals with Alzheimer's Disease/other dementia.)

b. Adults with a serious mental illness (SMI) and children and youth with serious emotional disturbance (SED) must be seen and evaluated by a licensed physician, licensed clinical psychologist, or psychiatric/mental health nurse practitioner as a part of the admission process to certify that the services planned are medically/therapeutically necessary for the treatment of the

individual. A licensed physician, licensed clinical psychologist, or psychiatric/mental health nurse practitioner must then physically visit and evaluate the status of the individual annually thereafter and recertify that the services being provided remain medically/therapeutically necessary.

b. A licensed certified (clinical) social worker may review a client's record for certification by a physician, licensed clinical psychologist or psychiatric/mental health nurse practitioner.

c. Certification and recertification (in a. and b. above) must be documented as part of the Comprehensive Individual Service Plan; and,

d. For individuals receiving Individual Therapeutic Support or Acute Partial Hospitalization, the individual case record must contain a physician's order for the service stating that inpatient care would be necessary without the specific service.

IV.H.9. A functional assessment, approved by the DMH, must be completed for each individual as follows:

a. For individuals admitted to outpatient mental health services for adults, a functional assessment must be conducted between thirty (30) days and sixty (60) days after Intake/Assessment and at least every twelve (12) months thereafter.

b. For individuals admitted to primary alcohol and drug treatment services (which include general outpatient services, DUI treatment services, and primary residential treatment programs), functional assessments and/or other performance measures must be implemented and data submitted as required by the Division of Alcohol and Drug Abuse;

c. For children and youth admitted to mental health services who have 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 guardian 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 Intake/Assessment process and/or of the next occurring Comprehensive Individual Service Plan review.

IV.H.10. Therapeutic activities provided to individuals receiving services must be documented in individualized Progress Notes, which at a minimum:

a. Include the following elements:

(1) A summary of the therapeutic activities of each contact;

(2) An assessment of the progress made toward goals and objectives of the Comprehensive Individual Service Plan, Aftercare Plan and/or Plan for Care for Alzheimer's Day Programs.

(3) A statement of immediate plans for future therapeutic activities.

b. Identify the date, type of service being rendered, and the length of time spent in providing the service.

Alcohol and Drug Services

IV.H.11. The Assessment/Educational Activities Documentation form must be completed for all individuals receiving substance abuse services (except for prevention-only programs) according to the following schedule:

a. All individuals receiving substance abuse treatment services must receive the TB and HIV/AIDS Risks Assessment at the time of the Intake/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 that both risk assessments were administered, with documentation of follow-up of results if applicable, in a primary treatment program completed within the last thirty (30) days.

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

b. All individuals receiving substance abuse treatment services must receive the educational information concerning HIV/AIDS, Sexually Transmitted Diseases, Tuberculosis, and the Mississippi Implied Consent Law as part of treatment either in an individual or group session according to the following schedule:

(1) Prior to completion of treatment for:

(a) Primary Residential Services;

(b) Transitional Residential Services unless the Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that the information was provided during primary treatment;

(c) Chemical Dependency Unit Services;

(d) Intensive Outpatient Services;

(e) Specific DUI Outpatient Treatment Tracks.

(2) Within ninety (90) days of the date of admission for:

(a) General Outpatient Services;

(b) Outreach/Aftercare Services unless the Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that the information was provided during substance abuse treatment.

IV.H.12. In addition to the Intake/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:

(1) Previous DUI's; and,

(2) Moving violations.

b. The results and interpretations of the Mortimer Filkins, SASSI, or other DMH approved diagnostic instrument. The approval must be obtained in writing.

IV.H.13. Providers of detoxification services must maintain documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the detox program and every two (2) hours during the second twenty-four (24) hours, and as needed thereafter, when prescribed by a physician.

IV.H.14. Providers of Transitional Residential Services must provide in the case records weekly documentation which addresses employment, vocational training, and/or academic activities.

IV.H.15. Providers of Aftercare Services must document in the case record at least one attempted contact per month, unless group, family or individual contact is documented during that month.

SECTION I- TRANSPORTATION OF INDIVIDUALS RECEIVING SERVICES

IV.I.1. 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, and maintenance;

b. When transporting individuals with intellectual/developmental disabilities in one vehicle, there must be one (1) additional staff in addition to the driver for every six (6) individuals.

c. When transporting children age 0-6 years in one vehicle, 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);

d.. When transporting any nonambulatory person(s) in one vehicle, the staff ratio in addition to the driver must be one (1) staff to six (6) persons being transported;

e. The vehicle must have a securely mounted/fixed fire extinguisher, flares or reflectors, a flashlight, and first aid kit which contains the following: gloves, adhesive bandages, gauze, tape, first aid tape, nonprescription pain relief tablets, sterile pads, antiseptic wipes, oval eye pads, a first aid booklet, and, for programs serving children, non-prescription, non-aspirin liquid pain reliever. Medications must not be expired;

f. All vehicles must have liability insurance unless not authorized by state law; and

g. 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.

IV.I.2. A transport log must be securely maintained in every program vehicle that provides transportation to individuals receiving services. The log must, at a minimum, contain the following information:

a. At time of pick-up:

(6) Vehicle identification (i.e. vehicle number or tag number).

(7) Name of the driver and additional staff (if applicable) on the vehicle.

(3) Names of individuals entering the vehicle.

b. At time of drop-off:

(1) Names of individuals exiting the vehicle

c. Any unusual occurrences during the route should be noted on the transport log.

IV.I.3. Upon arrival to the program site, the driver of the vehicle is responsible for delivering the transport log to program supervisory staff. The vehicle log must be reviewed by supervisory staff to ensure that all individuals receiving services at that program location have exited the vehicle and entered the program site. Upon verification that all individuals have entered the program site, the supervisory staff member must initial the transport log to verify that all individuals being transported have arrived at the program site.

IV.I.4. At the end of the program day, program staff must accompany individuals to their assigned program vehicle for transport. Program staff must supply the driver of the vehicle with a transport log that indicates who is being transported back to their place of residence. Procedures outlined for "time of pick-up" in Standard IV.I.2 should be followed for those individuals being transported to their places of residence. When the individuals arrive at their places of residence, procedures for "drop-off" must be followed.

IV.I.5. Upon completion of the transportation route, the driver of the vehicle and additional staff on the vehicle (if applicable) must review the transport log and verify that all individuals have been returned to their places of residence.

SECTION J- MEDICATION CONTROL

IV.J.1. Programs must have written policies and procedures and documentation of their implementation pertaining to medication control which assure that:

a. The administration of all prescription drugs and/or hazardous 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;

b. All medications must be clearly labeled. Labeling of prescription medications must also include the name of the individual for whom it was prescribed;

c. 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;

d. Adequate space is provided for storage of drugs that is well lighted and kept securely locked;

e. Medication stored in a refrigerator which contains items other than drugs will be kept in a separate locked compartment or container with proper labeling;

f. Drugs for external and internal use will be stored in separate cabinets or on separate shelves which are plainly labeled according to such use;

g. Prescription drugs will be stored in a separate cabinet or compartment from nonprescription drugs.

SECTION K – DISASTER PREPAREDNESS AND RESPONSE

IV.K.1. Providers must develop and maintain an emergency/disaster response plan for each service 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 location/site. For example, the location/site is located near an airport, railroad, nuclear power plant, typical path of tornado, earthquake zone, coastal region, etc. This plan must address at a minimum:

a. Lines of authority and Incident Command

b. Identification of a Local Disaster Coordinator

c. Notification and plan activation

d. Coordination of planning and response activities with local and state emergency management authorities

e. Assurances that staff will be available to respond during an emergency/disaster

f. Communication with individuals receiving services, staff, governing authorities, and accrediting and/or licensing entities

g. Accounting for all persons involved (staff and individuals receiving services)

h. Conditions for evacuation

i. Procedures for evacuation

j. Conditions for agency closure

k. Procedures for agency closure

l. Schedules of drills for the plan

m. 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;

n. The identified or established method of annual fire equipment inspection; and

o. Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.

IV.K.2. 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:

a. Identification of provider's essential functions in the event of emergency/ disaster.

b. Identification of necessary staffing to carry out essential functions

c. Delegations of authority

d. Alternate work sites in the event of location/site closure

e. Identification of vital records and their locations

f. Identification of systems to maintain security of and access to vital records

IV.K.3. Copies of the Emergency/Disaster Response Plans and the Continuity of Operations Plan should be maintained on-site for each location/site and at the agency's administrative offices.

IV.K.4. Emergency/disaster response plans and the continuity of operations plan must be reviewed annually by the governing body. Evidence of this annual review must be documented.

IV.K.5. All locations/sites must document, utilizing the standardized DMH form, implementation of the written plans for emergency/disaster response and continuity of operations. This documentation of implementation must include, but is not limited to the following:

a. Quarterly fire drills for day programs

b. Monthly fire drills for residential programs, conducted on a rotating schedule within the following time frames:

7 a.m. to 3 p.m.
3 p.m. to 11 p.m.
11 p.m. to 7 a.m.;

c. Quarterly disaster drills, rotating the nature of the event for the drill based on the emergency/disaster plan, for each facility and program.

d. Annual drill of Continuity of Operations Plan for the agency.

IV.K.6. Any revisions to the emergency/disaster response plans and the continuity of operations plan should be documented and approved by the agency's governing body. Any revisions should be communicated in writing to all staff.

IV.K.7. All community residential programs should maintain emergency/disaster preparedness supplies to support individuals receiving services and staff for a minimum of seventy two (72) hours post event. At a minimum, these supplies should include the following:

a. Non-perishable foods

b. Manual can opener

c. Water

d. Flashlights and batteries

e. Plastic sheeting and duct tape

f. Battery powered radio

g. Prescription and nonprescription medications based on needs of individuals in the program and guidance of agency medical staff

h. Personal hygiene items

~~PART III~~

~~HUMAN SERVICES~~

PART VII
~~SECTION A -~~ ENVIRONMENT/SAFETY

~~All programs must meet the environment/safety standards set forth in Section A - Environment/Safety listed under All Facilities (70.0-72.6). Programs providing Community Residential Services must meet the standards for All Facilities (70.0-72.6) and the Environment/Safety standards for Community Residential Services (73.0-73.8).~~

~~All Facilities~~
All DMH Certified Providers, regardless of type, must follow the procedures and standards outlined in this Part.

VII.ES.1. ~~70.0~~ All facilities must meet state and local fire, health, and safety codes with documentation maintained on site, as follows:

a. Facilities must be inspected and approved by appropriate local and/or state fire, health and safety agencies at least annually ~~(on or before anniversary date of previous inspection)~~ (within the anniversary month of the last inspection), and there must be written records of fire and health inspections.

b. Documentation by appropriate fire and health authorities that noted citations have been corrected must be maintained on-site.

c. Facilities with an existing sprinkler system must have annual inspection by a licensed company or the local fire authorities.

~~c~~.d. Facilities must provide evidence and documentation of a systematic pest control program. This documentation must be maintained on site.

f. The identified or established method of annual fire equipment inspection;

f. Evidence that fire extinguishers are being recharged or replaced after 6 years**;**

g. Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.

70.1γ All facilities must have a written plan of action in case of natural disasters or other traumatic events and an evacuation plan in case of fire that must include:

a. Policies and procedures for responding to natural disasters or other traumatic events;

b. A schedule for fire and disaster drills.

(1) Quarterly fire drills for day programs;

(2) Monthly fire drills for residential programs, conducted on a rotating schedule within the following time frames:

7 a.m. to 3 p.m.
3 p.m. to 11 p.m.
11 p.m. to 7 a.m.;

(3) Annual disaster drills conducted on or before the anniversary date of the previous drill.

c. The location of all fire extinguishing equipment, carbon monoxide detectors (if gas is used in facility) and alarms/smoke detectors;

d. The identified or established method of annual fire equipment inspection;

e. The assignment of tasks and responsibilities of staff by position during drills and disasters;

f. Escape routes and procedures that are specific to location/site and the type of disaster(s) for which they apply.

70.2γ All facilities must document implementation of the written plan of action above. This documentation of implementation must include, but is not limited to the following:

a. Documentation of quarterly fire drills for day programs;

b Documentation of monthly fire drills, conducted on the rotating time frames, for residential programs;

c. Documentation of annual disaster drills;

~~d. Documentation of annual inspection of fire extinguishing equipment and alarms/detectors;~~

~~e. Documentation of annual inspection of carbon monoxide detectors.~~

VII.ES.2. ~~70.3γ~~ Each facility must have at a minimum the following:

a. Operable fire extinguishing equipment and alarms/detectors located throughout the facility in all areas where conditions warrant (i.e. flammable storage areas, kitchens) and must be mounted in a secure manner;

b. Operable carbon monoxide detectors located in any facility where natural gas or any other source of carbon monoxide emission is used or where there is an open flame. One carbon monoxide detector must be located in every 1,000 square foot area or less.

VII.ES.3. ~~70.4γ~~ Escape routes must be posted in highly visible locations throughout the environment, clearly indicating where a person is located in relation to the nearest exit(s). ~~(Excludes Supervised Apartments and Supported Living)~~

~~70.5γ Written reports must follow each fire and disaster drill. Reports must include at a minimum:~~

~~a. Date, time, and type of drill;~~

~~b. Time required for accomplishing the goal of the drill, including time required for evacuation of the building (if appropriate to the type of drill conducted);~~

~~c. Names of staff participating in the drill;~~

~~d. A written assessment of the general performance of all persons participating in the drill;~~

~~e. Signature of staff member completing the report.~~

VII.ES.4. 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.

VII.ES.5. ~~70.6~~ The interior and exterior of each facility and program must be maintained in a safe and sanitary manner. This must include but not be limited to the following:

a. The water temperature in all hot water fixtures used by individuals enrolled in ~~Department of Mental Health~~ DMH programs must be maintained between 100 and 120 degrees Fahrenheit. Hot Water Heaters must be on a documented inspection schedule;

b. Emergency lighting systems 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 must be tested for a continuous length of at least 30 seconds per month and one continuous 4 hour test per year. Provider must maintain documentation of testing.

c. Any program that has a kitchen used by individuals receiving services from that program 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:

(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.

d. The facility including furnishings and/or the physical environment must be clean, well-kept and in good repair;

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

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

VII.ES.6. ~~70.7~~ Facilities 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).

VII.ES.7. ~~70.8~~ The clear width of doorways when the door is in the full open position must not be fewer than thirty-two (32) inches.

VII.ES.8. ~~70.9γ~~ 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.

~~71.0γ Locks, if provided on exit doors, must not require the use of a key for operation from inside the building.~~

VII.ES.9. Exterior doors shall be permitted to have key-operated locks from the egress side, provided that the following criteria are met:

a. 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.

b. The locking device is one that is readily distinguishable as locked.

c. A key is immediately available to any staff inside the building when it is locked.

d. There may only be one locked door per means of egress.

VII.ES.10. ~~71.1~~ At least one restroom must be accessible to individuals with physical disabilities ~~(Except for MR/DD Services see standard 500.5)~~ with either one accessible restroom for each sex or one accessible unisex restroom is acceptable. Additionally, non-residential programs serving individuals with ID/DD must have adequate private changing facilities.

VII.ES.11. ~~71.2~~ The accessible restroom stall must have grab bars behind the toilet and on the side wall nearest to the toilet and on the side wall nearest the lavatory/sink.

VII.ES.12. ~~71.3~~ 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.

VII.ES.13. ~~71.4~~ All doors, including stall doors in the restroom, must be operable with a closed fist from inside the exit.

VII.ES.14. ~~71.5~~ Restroom door locks must be designed to permit the opening of the locked door from the outside.

VII.ES.15. ~~71.6~~ Doors opening onto stairs must have a landing, at a minimum, the width of the door.

VII.ES.16. ~~71.7~~ Minimum head room on stairs to clear all obstructions must be six feet and eight inches (6' 8").

VII.ES.17. ~~71.8~~ Stairs in the program facility(ies) must have the following dimensions:

a. Stair width must be at least thirty-two (32) inches;

b. Minimum tread depth of each step of the stairs must be at least nine (9) inches;

c. Maximum height of risers in each step must not exceed eight (8) inches;

VII.ES.18. ~~71.9~~ 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.

a. Guards and handrails must continue for the full length of the ramp or stairs;

b. Handrails must provide at least one and one-half (1 2) inches between the inner side of the rail and support wall;

c. Handrails must be located between thirty (30) inches to thirty-four (34) inches above the tread of the step or ramp.

VII.ES.19. ~~72.0γ~~ Steps, ramps and platforms and landing(s) associated with them must be:

a. Designed for at least one hundred (100) pounds per square foot;

b. Have a slip-resistant surface.

VII.ES.20. ~~72.1γ~~ 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.

VII.ES.21. No portable heaters are allowed in service areas.

VII.ES.22. ~~72.2γ~~ Two (2) means of exit per living/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.

VII.ES.23. ~~72.3γ~~ 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 apartments/ supported living). The signs must be lighted at all times. In the case of electrical failure the illuminated lights should be battery operated in order to be readily visible.

VII.ES.24. ~~72.4γ~~ 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.

VII.ES.25. ~~72.5~~ Any program that has drinking fountains must have at least one fountain that meets the following specifications:

a. Has clear floor space of at least 30 by 48 inches in front;

b. Has a spout no higher than 36 inches from the floor;

c. Has controls mounted on front or side near the front edge and be operable with a closed fist.

VII.ES.26. ~~72.6~~ Each program must have a first aid kit. The kit must contain gloves, adhesive bandages, gauze, tape, first aid tape, nonprescription pain relief tablets, sterile pads, antiseptic wipes, oval eye pads, a first aid booklet, and, for programs serving children, non-prescription, non-aspirin liquid pain reliever. 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.

VII.ES.27. ~~72.7~~ heat, All facilities must have operational utilities (light, water/sewer, electricity). Facilities must also have a plan in place in case utilities fail.

~~Community Residential Services~~

~~In addition to meeting standards 70.0 through 72.6 for all facilities, community residential services programs must also meet standards 73.0 through 73.8 that follow.~~

~~73.0 The building must be located in a residential area of the community approved by the Department of Mental Health. Retail stores and/or shopping centers, public recreation facilities, and churches must be in a reasonable proximity to the residence.~~

~~73.1 Bedrooms must meet the following specifications:~~

~~a. All bedrooms for residents must have an outside exposure at ground level or above. Windows must not be over forty-four (44) inches off the floor. All windows must be operable.~~

~~b. Resident bedrooms must meet the following dimension requirements:~~

~~(1) Single room occupancy - at least 100 sq. ft.~~

~~(2) Multiple occupancy - at least 80 sq. ft. for each bed.~~

~~c. Resident bedrooms must house no more than three (3) persons each, except for MR/DD programs which must meet Standard 900.2.~~

~~d. 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.~~

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

f. All resident bedrooms must be located so that the resident may go from bedroom to required outside exit, living room, day room, dining room, toilet, or bathing facility without having to go through another resident bedroom.

g. Single beds must be provided with a good grade of mattress which is at least four (4) inches thick. Cots or roll-away beds may not be used.

h. Each bed must be equipped with a 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 and allow for emergencies.

i.γ Auditory smoke/fire alarms with a noise level loud enough to awaken residents must be located in each bedroom and in hallways and/or corridors.

73.2 Community Living/residential programs must, to the maximum extent possible, duplicate a home environment. The furnishings must be items that are safe, comfortable, appropriate, and adequate.

a. Each community living/residential program must have a bathroom that contains at least one operable toilet and one operable lavatory/ sink for each six (6) residents and one operable shower or tub for each eight (8) residents.

b. Bathtubs and showers must be equipped with:

(1) Soap dishes;

(2) Towel racks;

(3) Shower curtains or doors;

(4) Grab bars.

c. Living rooms, day rooms, and/or recreation rooms must be provided for residents and visitors.

(1) Facilities housing less than ten (10) persons must have at least one visiting area.

(2) Facilities housing ten (10) or more persons must have two (2) visiting areas.

(3) The living room must be equipped with attractive, functional furniture with sufficient seating space to accommodate all residents.

d. The laundry must have an exterior mechanical ventilation system.

e. Each community living/residential program must have separate storage areas for:

(1) Sanitary linen;

(2) Food (No food supplies may be stored on the floor.);

(3) Cleaning supplies.

f. An adequate heating and cooling system must be provided to maintain temperature between 68 degrees and 78 degrees Fahrenheit.

73.3γ In community living/residential program, each bedroom and living room area must have at least two (2) means of escape, one (1) of which must be a door or stairway providing a means of unobstructed travel to the outside of the building at street or ground level.

73.4 Except in apartments, the designated exit door(s), preferably nearest the residents' bedrooms, must consist of a lever action continuously open, one way locking door to permit exit from the inside to the outside, but restricting entry from the outside to the inside.

73.5 No required path of travel to the outside from any room shall be through another room or apartment not under the immediate control of the occupant of the first room, nor through a bathroom or other space subject to locking.

73.6γ Community living/residential programs which have buildings of two (2) 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.~~

~~73.7 All employees working in community living/residential programs must, before reporting to work, furnish the employer with a physician's statement which verifies that the employee is sufficiently free from disease and does not have any health condition that would create a hazard for other clients or employees.~~

~~73.8 All individuals admitted to community living/residential programs must have a medical screening by a licensed physician or certified nurse practitioner, including a statement from the examiner which verifies that the individual is sufficiently 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 residential services program without such required documentation. This screening must be completed prior to admission but no earlier than thirty (30) days prior to admission.~~

SECTION ~~B~~ E- SERIOUS INCIDENT REPORTS AND RECORDS

V.E.1. ~~80.0~~ All serious incidents involving an individual receiving services or a staff member on program property or at a program-sponsored event must be reported to the ~~Department of Mental Health~~DMH, Office of Constituency Services, the agency director, parent(s)/guardian(s) or other significant persons as identified by the individual receiving service and documentation of such incident report maintained in a central file on site.

V.E.2. ~~80.1~~ A written policy for documenting and reporting all serious incidents must be in place locally. Documentation regarding serious incidents must include a written description of events and actions, written reports and telephone calls to the ~~Department of Mental Health~~DMH, Office of Constituency Services.

V.E.3. ~~80.2~~ Serious incidents (such as those described in Standard ~~80.3~~V.E.4.) must be reported to the ~~Department of Mental Health,~~DMH Office of Constituency Services as soon as possible, but no later than 24 hours, in one of the following ways:

a. The Serious Incident Report Form documenting a description of the incident, action and resolution must be submitted to the

~~Department of Mental Health~~DMH, Office of Constituency Services as soon as possible, but no later than within 24 hours or;

b. A report must be made to the ~~Department of Mental Health~~ DMH, Office of Constituency Services by telephone as soon as possible, but no later than within 24 hours or the next working day, followed by a completed written Serious Incident Report Form documenting a description of the incident, action and resolution. The Serious Incident Report form must be received by the Department of Mental Health within five working days of the incident.

V.E.4. ~~80.3 γ~~ The following are examples of types of serious incidents that must be reported to the Department of Mental Health, Office of Constituency Services and other appropriate authorities within 24 hours or the next working day, as specified below:

a. Suicide attempts on program property or at a program-sponsored event.

b. Unexplained absence from a residential program of twenty-four (24) hour duration.

c. Absence of an individual receiving services of any length of time from an adult day center providing services to persons with Alzheimer's disease and/or other dementia (i.e., wandering away from the premises) must be reported to the Department of Mental Health, Office of Constituency Services within 24 hours of its occurrence.

d. Death of an individual on program property or program-sponsored event or during an unexplained absence from a residential program site.

e. Emergency hospitalization or emergency room treatment of an individual while in the program.

f. Accidents which require hospitalization, may be related to abuse or neglect, or in which the cause is unknown or unusual.

g. Disasters, such as fires, floods, tornadoes, hurricanes, blizzards, etc.

h. Any type of mandatory evacuation by local authorities that affects the program/facility or site,

~~h.~~i. Use of seclusion or restraint~~. (See also Section C that follows.)~~

V.E.5. Death of an individual on program property, participating in a program-sponsored event, being served through a certified residential program, or during an unexplained absence of the individual from a residential program site must be reported verbally to the Office of Constituency Services within eight (8) hours to be followed by the required serious incident form within twenty-four (24) hours.

NOTE: This list is not intended to be exhaustive. Programs should use discretion. If there is doubt, contact the Department of Mental Health, Office of Constituency Services.

SECTION ~~C~~ A- RIGHTS OF INDIVIDUALS RECEIVING SERVICES

V.A.1. ~~90.0*~~ There must be written policies and procedures and written documentation in the record that each individual receiving services and/or parent(s)/legal guardian(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. The individual receiving services and/or parent/legal guardian must also be given a written copy of these rights, which at a minimum, must include:

a. The options within the program and of other services available;

b. Program rules and regulations;

c. Program's responsibility for the referral of those persons whom the program is unequipped to serve;

d. The right to refuse treatment;

e. The right not to ~~be subjected to corporal punishment or unethical treatment~~ ethical treatment including but not limited to the following:

(1) The right not to be subjected to corporal punishment;

(~~1~~)(2) The right to be free from all forms of abuse or harassment;

~~(2)~~ (3) The right to be free from restraints of any form that are not medically necessary or are used as a means of coercion, discipline, convenience or retaliation by staff.

i. The right to considerate, respectful treatment from all employees and volunteers of the provider program**.**

f. The right to voice opinions, recommendations, and to file a written grievance which will result in program review and response without retribution. ~~(See also Part II, Organization and Management, Section G – Grievance and Complaint Resolution);~~ (See also Part II, Organization and Management, Standard II.A.5. and Part V, Rights of Individuals Receiving Services, Section F.);

g. The right to personal privacy, including privacy with respect to facility visitors in day programs and residential programs as much as physically possible;

h. The program's nondiscrimination policies related to HIV infection and AIDS;

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

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

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

l. The right to participate in and receive a copy of the comprehensive treatment/habilitation/service plan including but not limited to the following:

(1) The right to make informed decisions regarding his/her care, including being informed of his/her health status, being involved in care planning and treatment and being able to request or refuse treatment. This right must not be construed as a mechanism to demand the provision of treatment or services deemed medically unnecessary or inappropriate.

(2) The right to access information contained in his/her clinical records 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 medical records and must actively seek to meet these requests as quickly as its record keeping system permits. State statute 41-21-102 (7) does allow for restriction to access to records in certain circumstances where it is medically contraindicated; and,

(3) The right to be informed of any hazardous side effects of medication prescribed by staff medical personnel.

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

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

o. The right to receive care in a safe setting.

V.A.2. ~~90.1 γ~~ Providers must establish and implement written policies and procedures specifying that:

a. Providers are prohibited from the use of mechanical restraints, unless being used for adaptive support.

b. Providers are prohibited from the use of seclusion except for certified ~~Intensive Residential Treatment Services (See Part VIII, Section M.).~~
Crisis Stabilization Units (See Standard XI.J.34 through XI.J.36).

c. Providers are prohibited from the use of chemical restraints.

The definition of seclusion, mechanical restraint and chemical restraint are as follows:

(1) Seclusion means a behavior control technique involving locked isolation. Such term does not include a time out.

(2) 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;

(3) A chemical restraint is a ~~drug or~~ medication that is used as a restraint to manage behavior or restrict the individual's freedom of movement that is not a standard treatment for the individual's medical or psychiatric condition;

V.A.3. ~~90.2 γ~~ Providers must ensure that all staff who may utilize physical restraint(s)/escort successfully complete training and hold a nationally recognized or DMH-Approved Program for managing aggressive or risk-to-self behavior.

V.A.4. Providers must maintain a listing of all supervisory or senior staff members who have successfully completed required training and demonstrate competency in utilization in physical restraint(s).

V.A.5. ~~90.3. γ~~ Providers utilizing physical restraint(s)/escort must establish and implement written policies and procedures specifying appropriate use of physical restraint/escort. The policy/procedure must include, at a minimum;

a. Clear definition(s) of physical restraint(s)/escort and the appropriate conditions and documentation associated with their use;

(1) 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;

(2) 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;

b. 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. AEmergency@ 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 (see ~~90.4b~~ V.A.6. for need of Behavior Support Plan);

c. Requirements that physical restraints/escorts are used as specified in the Behavior Support 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;

d. Requirements that physical restraint(s)/escort are being used in accordance with a Behavior Support 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.

V.A.6. ~~90.4 γ~~ 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 and in each individual case record:

a. 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);

b. 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 day period with the same individual. The Behavior Support Plan must address the behaviors warranting the continued utilization of physical restraint(s)/escort procedure in emergency situations. The Behavior Support Plan must be developed with the signature of the program's clinical director.

c. In physical restraint situations, the treating physician must be consulted within twenty-four hours and this consultation must be documented in the individual's case record.

d. 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 hour of initiation of the intervention. Procedures must also ensure that the supervisory or senior staff person trained as per Standard ~~90.2~~ V.A.3. monitors the situation for the duration of the intervention;

e. Requirements that staff record 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. The log must include:

(1) Name of the individual for whom the physical restraint(s)/escort intervention is implemented;

(2) Time that physical restraint(s)/escort intervention began;

(3) Behavior warranting utilization of physical restraint(s)/escort intervention;

(4) Type of physical restraint(s)/escort that was utilized during intervention.

(5) Documentation of less restrictive alternative methods of managing behavior which have been determined to be ineffective in the management of the individual's behavior.

(6) Documentation of visual observation by staff of individual while he/she is in physical restraint(s)/escort, including description of behavior at that time;

(7) Time that the physical restraint(s)/escort intervention ended;

(8) Signature of staff implementing physical restraint(s)/escort procedure and staff observing individual for whom physical restraint(s)/escort intervention was implemented.

(9) Documentation of supervisory or senior staff person's assessment of the restrained/escorted individual's mental and physical well-being during and after physical restraint(s)/escort utilization, including the time the assessment was conducted.

(10) Documentation of the use of physical restraint(s)/escort in emergency situations must clearly describe the precipitating events that necessitated their use.

V.A.7. ~~90.5 γ~~ 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) minutes at any one time. They must be released after those sixty minutes. A face-to-face assessment must take place at least every twenty (20) minutes while the individual is being restrained.

V.A.8. ~~90.6 γ~~ 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 treatment/service/habilitation plan of the individual being served as well as all of the following:

a. Requirement(s) that physical restraint(s)/escort must be implemented in the least restrictive manner possible;
b. Requirement(s) that physical restraint(s)/escort must be in accordance with safe, appropriate restraining techniques; and;

c. 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 in no longer in danger of harming him/herself or others;)

d. Requirement(s) that physical restraint(s)/escort must not be used as a form of punishment, coercion or staff convenience;

e. Requirement(s) that supine and prone restraints are prohibited as part of an individual's Behavioral Support Program; and

f. Requirement(s) that all physical restraint(s)/escort can only be implemented by someone holding certification as per Standard ~~90.2~~.V.A.3.

V.A.9. ~~90.7 γ~~ 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 policy/ procedures must include, at a minimum, the following provisions:

a. Clear definition(s) of time-out and the appropriate conditions and documentation associated with its use:

(1) 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.

(2) 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.

b. Requirement(s) ensuring that the use of time-out procedures is justified as documented and approved in a comprehensive treatment/ service/habilitation plan;

c. Requirement(s) ensuring that time-out be 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; and

d. Requirement(s) that a locked door must not be component of timeout.

V.A.10. ~~90.8 γ~~ 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 can not exceed one hour.

V.A.11. ~~90.9 γ~~ There must be written and implemented policies and procedures requiring that a Behavior Support Plan be developed by the individual's treatment 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:

a. The Behavior Support Plan must be developed in accordance with the individual's comprehensive treatment/habilitation plan and have signature approval by the program's clinical director.

b. The Behavior Support Plan must not include the use of time out as a form of punishment, coercion or for staff convenience.

V.A.12. ~~91.0~~ The utilization of time-out must be documented in a behavior log completed/maintained in the individual's case record which, at a minimum, must include:

a. Name of the individual for whom the time-out intervention is implemented;

b. Time that time-out intervention began;

c. Behavior(s) requiring time-out intervention;

d. Documentation of visual observation by staff while individual is in time-out, including description of behavior at that time;

e. Time that the intervention ended; and

f. Signature of staff implementing procedure and observing individual for whom time-out intervention was implemented.

V.A.13. ~~91.1 γ~~ In the case of residential placement, the program must have written and implemented policies and procedures that:

a. Provide the individual receiving services with means of communicating with persons outside the program;

b. Provide for visitation by close relatives and/or significant others during reasonable hours;

c. Provide for safe storage, accessibility and accountability of funds of individuals receiving services;

d. Provide for individuals to send/receive mail without hindrance;

e. Provide for individuals to conduct private telephone conversations with family and friends, unless clinically contraindicated and documented in the individual case record. (Any individual restriction on private telephone use must be reviewed at a minimum every seven days).

V.A.14. ~~91.2~~ 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 or the program must have a policy that the individuals do not work for the program.

V.A.15. ~~91.3~~ A record of any individuals for whom the provider is a conservator or a representative payee must be on file with supporting documentation.

V.A.16. ~~91.4~~ For programs serving as conservator or representative payee, the following action must be taken for each individual:

a. 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;

b. The individual and/or his/her lawful agent 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.

V.A.17. ~~91.5~~ All programs that provide services for children under the age of eighteen (18) must have on file an assurance signed by the Executive Officer of the provider stating compliance with provisions of Public Law 103-227 (Pro-Children Act of 1994). Note: This standard includes a current ACertification Regarding Environmental Tobacco Smoke@ required of providers funded by the Department of Mental Health.

V.A.18. In all Alcohol and Drug Abuse Residential programs, smoking is prohibited within ten (10) feet of the main entrance.

SECTION B- STAFF ROLES IN PROTECTING RIGHTS OF INDIVIDUALS

V.B.1. The program 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 guardians/legal representative.

V.B.2. The program's policies and procedures must be written in such a way that staff member's roles in maintaining or explaining these rights is clearly defined.

V.B.3. The policies and procedures must also clearly explain how the program will train staff members with 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 guardian/legal representative. Training should focus on the population to be served, but can include other related areas for broadened understanding. Training should include, but is not limited to:

a. The effects of stigma,

b. Developing empathy, and

c. The roles of family members and caregivers in treatment and services.

SECTION C- ETHICAL CONDUCT

V.C.1. In addition to complying with ethical standards set forth by any relevant licensing or professional organizations, 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. Examples of breeches of ethical or moral conduct toward individuals, their families, or other vulnerable persons, include but are not limited to, the following:

m. Borrowing money or property;

n. Accepting gifts of monetary value;

o. Sexual (or other inappropriate) contact;

p. Entering into business transactions or arrangements;

q. Physical, mental or emotional abuse;

r. 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;

s. Exploitation;

t. Failure to maintain proper professional and emotional boundaries;

u. Aiding, encouraging or inciting the performance of illegal or immoral acts;

v. Making reasonable treatment-related needs of the individual secondary or subservient to the needs of the employee or volunteer;

w. Failure to report knowledge of unethical or immoral conduct or giving false statements during inquiries to such conduct; and,

x. Action or inaction, which indicates a clear failure to act in an ethical, moral, legal, and professional manner.

SECTION D- CULTURAL COMPETENCY/ LIMITED ENGLISH PROFICIENCY SERVICES

V.D.1. Language assistance services, including bilingual staff and interpreter services, must be offered at no cost to individuals receiving services with limited English proficiency at all points of contact.

V.D.2. Language assistance services must be offered in a timely manner during all hours of operation.

V.D.3. 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.

V.D.4. Service providers must assure the competence of the language assistance provided.

V.D.5. Family and/or friends of the individual receiving services should only be utilized to provide interpreter services when requested by the individual receiving services.

V.D.6. Service providers must make available easily understood consumer related materials and post signage in the language of groups commonly represented in the service area.

SECTION ~~D~~ G- CONFIDENTIALITY

~~Maintaining confidentiality of information about individuals served through all programs certified under these standards is an important aspect of any program's integrity. Constant awareness of maintaining confidentiality, as well as other rights of individuals served by the program and described elsewhere in these standards, should be stressed in employee orientation and training programs.~~

IV.G.1. ~~100.0*~~ 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.

IV.G.2. ~~100.1*~~ The program 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. 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:

a. Designated person(s) to distribute records to staff;

b. Specific procedures to assure that records are secure in all locations;

c. 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;

d. 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 continue benefits of the individual. These procedures at a minimum must:

(1) Describe the process for releasing information about an individual receiving services only upon written consent, including the identification of the staff responsible for processing inquiries or requests for client information;

(2) Describe the process for releasing information about an individual receiving services without prior written consent, that is, in cases of a medical emergency or upon receipt of a court order;

(3) Specify staff authorized to make such release and require that the following is compiled and placed in the record of the individual receiving services:

(a) Individual's name or case number;

(b) Date and time of disclosure;

(c) Information disclosed;

(d) To whom information was disclosed and the reason for disclosure.

(e) The name, credential, and title of the individual disclosing the information.

e. 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;

f. 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;

g. Procedures requiring written consent of the individual receiving services or their guardian, when appropriate, prior to disclosing identifying information to third-party payer;

h. Procedures addressing the release of information regarding individuals receiving alcohol and drug abuse services, in accordance with applicable federal regulations.

IV.G.3. ~~100.2~~ 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.

IV.G.4. ~~100.3~~ All case records must be marked "confidential" or bear a similar cautionary statement.

IV.G.5. ~~100.4~~ The consent to release information form must include:

a. The name of the program which is to make the disclosure;

b. The name or title of the person or organization to which disclosure is to be made;

c. The name of the individual receiving services;

d. The purpose or need for the disclosure;

e. A statement that the consent may be revoked at any time except when action on it has already been taken;

f. The specific condition, event, or date on which the consent will automatically expire, not to exceed twelve months;

g. The extent and nature of information to be disclosed;

h. The date when consent is signed;

i. The signature of the individual receiving services or the signature of a person who is either authorized to give consent or authorized to sign in lieu of the individual;

j. The signature of a witness to the authorization by the individual receiving services to release/obtain information.

IV.G.6. ~~100.5~~ In the case of a community residential program, the program must:

a. Obtain prior written consent from the individual living in the residence or legal representative prior to acknowledging his or her presence in the facility to visitors or to callers;

b. Assure that documentation of such consent is maintained in the case record.

IV.G.7. ~~100.6~~ No program shall release records of individuals receiving services for review to a state or federal reviewer other than Department of Mental Health staff without a written statement indicating:

a. The purpose of the review;

b. Staff to conduct the review;

c. That reviewer(s) are bound by applicable regulations regarding confidentiality and all others that apply;

d. Reviewer(s) signature(s) and the date signed.

SECTION ~~E~~ H- CASE RECORD MANAGEMENT AND RECORD KEEPING

~~Standards that follow include requirements pertaining to all case records for individuals receiving mental health, mental retardation/developmental disabilities service and/or~~

~~supports, substance abuse services, and services for individuals with Alzheimer's disease and other dementia. Providers must also meet case records standards pertaining to individual service or program areas and contained in Parts IV through X.~~

~~200.0* Bureau of Mental Retardation services must meet the standards herein and the requirements outlined in the Bureau of Mental Retardation Record Guide and Part IV of the Minimum Standards.~~

~~200.1* Bureau of Mental Health services must meet the standards herein and the requirements outlined in the Bureau of Mental Health Record Guide. Programs must utilize the forms included in the record guide. Items specifically customized for a program's in-house procedures can be added.~~

IV.H.1. All providers must meet the standards herein and the requirements outlined in the MS DMH Record Guide.

IV.H.2. ~~200.2~~ The program must maintain an indexing or referencing system that allows for locating particular individual case records whenever they are removed from the central file area.

IV.H.3. ~~200.3~~ Records of individuals served by the program must be readily accessible to authorized treatment personnel and there must be written procedures assuring accessibility to records by emergency staff after hours.

IV.H.4. ~~200.4~~ All entries in records of individuals served by the program must be 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. Correction fluid, erasing, or totally marking out original information is not permissible.

IV.H.5. No progress notes in the individual record shall contain the name or other identifiable information of another individual receiving services.

IV.H.6. Individual records must be closed when there has been no contact for a twelve (12) month period. For alcohol and drug services records, the case must be closed when no contacts are recorded for ninety (90) days.

IV.H.7. ~~200.5~~ Record must be maintained for all individuals served by the program and must contain (when applicable) the following information:

a. Face Sheet or Identification Data Form;

b. Intake/Assessment;

c. Comprehensive ~~Treatment~~ Individual Service Plan or Service/Habilitation/Activity Plan or Needs Assessment/Aftercare Plan or Plan of Care (for Alzheimer's Day Programs);

d. Case Management Life Domains Assessment/Service Plan;

e. For individuals receiving alcohol and drug abuse services:

(1) Assessment/Educational Activities Documentation Form;

(2). Needs Assessment/Aftercare Plan;

(3) Documentation of detoxification monitoring for primary residential programs;

(4) Documentation of vocational, educational, employment, or related activities for transitional residential program.

~~d.~~ f. Documentation of initial staffing and each subsequent staffing/ review;

~~e.~~ g. Progress Notes and/or Contact Summaries;

~~f.~~ h. Medication/Drug Use Profile;

~~g.~~ i. Discharge/Termination Summary;

~~h.~~ j. Copies of all signed Consent to Treatment, Acknowledgment of Individual's Rights, and Release of Information forms;

~~i.~~ k. Any evaluations and diagnostic assessments;

~~j.~~ l. Any applicable Department of Mental Health checklist and certification of eligibility;

~~k.~~ m. Consent to release information acknowledging presence of individual served by the program to visitors (if applicable);

~~l.~~ n. For individuals who have a legal guardian/conservator appointed by a court of competent jurisdiction, copies of the guardian/conservator order.

o. Copies of any court orders pertaining to outpatient mental health/substance abuse and rehabilitation treatment.

p. For youth served in therapeutic group homes and therapeutic foster care programs:

(1) Documentation that information required in **Standard XI.D.1** has been explained/provided in writing to the parent(s), legal guardian(s), and youth prior to or upon admission to the program;

(2) Results of dental examination required in **Standard XI.C.5**;

(3) Current photograph of the youth;

(4) Educational records and reports;

(5) Copies of any current court order pertaining to the treatment or custody of the youth;

(6) Any permission forms signed by the parent(s)/legal guardian(s) for the youth to participate in specific program activities;

i. Permission form(s) for staff to provide first aid.

200.6 The Face Sheet/Identification Data Form must consist of data items specified in the Core Client Data Set in the current Mississippi Department of Mental Health Manual of Uniform Data Standards and ancillary data as required by the Department of Mental Health. The Face Sheet/Identification Data form must be in the record of the individual receiving services and must be completed within time lines specified for intake/assessment for new admissions. The face sheet must be updated as needed and reviewed at least annually. The date of the annual review must be initialed and included in the client record.

200.7 All case records for individuals served in the program must contain a Discharge/Termination Summary for closed cases that includes:

a. Reason for admission;

b. Brief summary of therapeutic activities provided;

c. Reason for discharge;

d. Assessment of progress toward Treatment Plan or Habilitation/ Service/Activity Plan, Needs Assessment/Aftercare Plan or Plan of Care objectives;

e. Discharge instructions given to the individual who received services or their authorized representative, parent(s)/legal guardian(s), including referrals made;

f. Any other information deemed appropriate to address the needs of the individual being discharged from the program.

~~SECTION F - MEDICATION CONTROL~~

~~300.0γ Programs must have written policies and procedures and documentation of their implementation pertaining to medication control which assure that:~~

~~a. The administration of all prescription drugs and/or hazardous 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;~~

~~b. All medications must be clearly labeled. Labeling of prescription medications must also include the name of the individual for whom it was prescribed;~~

~~c. 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;~~

~~d. Adequate space is provided for storage of drugs that is well lighted and kept securely locked;~~

e. Medication stored in a refrigerator which contains items other than drugs will be kept in a separate locked compartment or container with proper labeling;

f. Drugs for external and internal use will be stored in separate cabinets or on separate shelves which are plainly labeled according to such use;

g. Prescription drugs will be stored in a separate cabinet or compartment from nonprescription drugs.

SECTION G - TRANSPORTATION OF INDIVIDUALS RECEIVING SERVICES

400.0γ 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, and maintenance;

b. When transporting individuals with mental retardation/developmental disabilities in one vehicle, there must be one additional staff in addition to the driver for every six individuals.

c. When transporting children age 0-6 years in one vehicle, 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);

d.. When transporting any nonambulatory person(s) in one vehicle, the staff ratio in addition to the driver must be one (1) staff to six (6) persons being transported;

e. The vehicle must have a securely mounted/fixed fire extinguisher, flares or reflectors, a flashlight, and first aid kit which contains the following: gloves, adhesive bandages, gauze, tape, first aid tape, nonprescription pain relief tablets, sterile pads, antiseptic wipes, oval eye pads, a first aid booklet, and, for programs serving children, non-prescription, non-aspirin liquid pain reliever. Medications must not be expired;

f. ~~All vehicles must have liability insurance unless not authorized by state law;~~

g. ~~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.~~

~~PART IV~~

~~COMMUNITY MENTAL RETARDATION/~~
~~DEVELOPMENTAL DISABILITIES SERVICES~~

Standards contained in this section apply to Bureau of Mental Retardation/Developmental Disabilities Programs. The sponsoring agency/provider for such programs and services must meet standards in Part II – Organization and Management, Part III – Human Services, and Part IV-Community Mental Retardation/Developmental Disabilities Services.

Providers/sponsoring agencies seeking to provide: Intake/Biopsychosocial Assessment; Individual Therapy, Family Therapy, Group Therapy, Multi-Family Therapy (Outpatient Therapy Services); Treatment Plan Review; Mental Illness Monitoring Services; School-Based Services; Individual Therapeutic Support; Day Support; Elderly Psychosocial Rehabilitation; Day Treatment for Children; Acute Partial Hospitalization; Medication Evaluation and Monitoring; Nursing Assessment; and Medication Injection to individuals with mental retardation/developmental disabilities must also meet Part I - Procedures for Certification, Part II - Organization and Management, Part III - Human Services, Part IV – Community Mental Retardation/Developmental Disabilities Services, Section A – General Standards, as well as standards in applicable sections in Parts VI - Children and Youth Community Mental Health Services, VIII – Adult Community Mental Health Services, and X – Other Community Services for Individuals with Mental Illness, Mental Retardation/ Developmental Disabilities or Substance Abuse Diagnoses.

SECTION A - GENERAL STANDARDS

500.0* Programs are required to adhere to the record system and time lines as established in the Bureau of Mental Retardation Record Guide.

500.1 No individual's record shall contain the name or other identifiable information of another person receiving services.

500.2* Individuals with a diagnosis of mental retardation who also receive mental health services through a community mental health center must be recertified for mental health treatment annually by a physician or licensed psychologist. This recertification must contain appropriate documentation stating that the service is medically necessary and must be maintained in the individual's record.

500.3 Each service provider must have a schedule available to individuals and their families for each service which includes, at a minimum:

a. Hours of daily operation/hours service is available;

b. Number of days per year the service will be provided/is available; and

c. Scheduled dates of closure/unavailability and reasons.

500.4 For day and residential programs, emergency telephone numbers must be posted in a conspicuous location near each telephone. Numbers must be included for:

a. Police;

b. Fire;

c. Poison Control Center; and

d. Ambulance/Emergency Medical Services (EMS).

500.5 Day programs (e.g., work activity, day habilitation, etc.) serving 15 or more people must have at least two restrooms. One of these restrooms must be accessible for individuals with disabilities. Additionally, adequate changing facilities that provide privacy and preserve personal dignity must be available when necessary to meet an individual's needs.

500.6γ All programs must provide the level of staffing needed to ensure the health, safety, and welfare of the individuals served.

500.7 The day to day provision of services must be under the supervision of staff who meet the minimum requirements defined in Part II, Section B, Personnel Policies and who are qualified by demonstrated competence, specialized background, education, and experience to manage the operation of the program.

500.8 Providers must submit all reports required by the Bureau of Mental Retardation according to the established time lines.

500.9 When services are not immediately available, each individual must be offered case management services with documentation of such maintained in the individual's record.

501.0 The written policy and procedure manual must describe the placement of individual services for which the provider is certified within the agency's organizational structure.

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

a. Describe the process for admission or readmission to service(s);

b. Define the criteria for admission or readmission to service(s), including:

(1) Description of the population to be served (age(s), eligibility criteria, any special populations, etc.);

(2) Process for determination of eligibility for adult service(s) offered by the provider.

c. Describe the process or requirements for collecting intake/assessment information including the process for requesting appropriate consent to obtain relevant records from other providers.

d. Describe written materials provided to adults upon admission, including materials that may be included in an orientation packet, etc.

e. Describes the process for informing individuals of their rights and responsibilities (including any applicable program rules for residential programs) prior to or at the time of admission.

f. Describe the process to be followed when an individual is found ineligible for admission or readmission to service(s) offered by the provider, including referral to other agencies and follow-up, as appropriate. Such referral(s) and follow-up contacts must be documented.

g. Describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available by the provider.

501.2* Written policies and procedures must address all staff's responsibilities and roles in protecting the rights of the individual served by the provider as described in Part III, Section C - Rights of Individuals Receiving Services.

501.3 In addition to applicable minimum standards, programs funded by the Mississippi Department of Mental Health must comply with any additional specifications set forth in individual program grants/contracts.

HCBS Waiver Programs

~~The Home and Community Based Services – MR/DD Waiver provides services to persons who receive Medicaid benefits and who have mental retardation/developmental disabilities and would require the level of care found at an intermediate care facility for the mentally retarded (ICF/MR) if these services were not available. A person must be determined eligible for the HCBS Waiver by one of the Diagnostic and Evaluation Teams at one of the five state regional centers and then be approved by the Division of Medicaid.~~

~~510.0* At least within one year prior to employment and annually thereafter, all HCBS Waiver staff (including substitutes) who have any direct contact with eligible individuals must have a PPD tuberculin skin test unless a previously positive reaction can be documented. If a person has previously tested positive, he/she must provide documentation of the action taken and provide an annual physician's statement indicating they are free of the signs and symptoms of tuberculosis. Persons with untreated active tuberculosis must not have any direct contact with eligible individuals.~~

~~510.1* The number of units and service(s) provided to each individual is dependent upon the individual's needs as set forth in the individual's Plan of Care. Service providers will receive prior written authorization from the HCBS Waiver Support Coordinator indicating the amount of service that each individual is approved to receive. Services or amounts of service provided which exceed the amount authorized by the HCBS Waiver Support Coordinator will not be reimbursed and funds will be recouped.~~

~~510.2* Reimbursement can only be requested by providers if all HCBS Waiver requirements have been met. HCBS Waiver funds may be recouped for the following reasons:~~

~~a. Lack of documentation, as defined in the Bureau of Mental Retardation Record Guide, to support the amount of time billed;~~

~~b. Staff providing services do not meet the minimum requirements as outlined in Part II, Section B, Personnel Polices;~~

~~c. Submission of billing to the current Medicaid fiscal agent, yet not submitting the required documentation for billing to the appropriate HCBS Waiver Support Coordinator according to the time lines established in the Bureau of Mental Retardation Record Guide;~~

d. Using forms for documentation purposes that are not included in the Bureau of Mental Retardation Record Guide for the HCBS Waiver;

e. Providing services outside the scope of the service definition as outlined in the Minimum Standards for Community Mental Health/ Mental Retardation Services;

f. Improper completion of required forms used for documentation of services provided;

g. Absence of required forms used for documentation of services provided; and/or

h. Providing services or amounts of service which have no prior authorization by the HCBS Waiver Support Coordinator.

510.3* Services approved on an individual's Plan of Care cannot be rendered simultaneously unless the services are distinct in nature (e.g., a person might receive Behavior Support/Intervention Services while attending a day habilitation program) and are prior approved by the HCBS Waiver Support Coordinator.

510.4* All HCBS Waiver service providers are responsible for submitting their own claims to the Division of Medicaid/current fiscal agent and for maintaining copies of each claim in each individual's record.

Bureau of Mental Retardation Residential Programs

520.0 All residential programs must develop written procedures for setting and collecting fees (in accordance with Standard 30.1.). Additionally, these procedures must include development, and result in documentation, of a written financial agreement with each individual or parent/legal guardian (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 guardian and provided in two (2) or more copies, one (1) copy given to the individual/parent/legal guardian, and one (1) copy placed on file in the individual’s record; and

c. Does not relieve the provider of the residential program of the responsibility for the protection of the person and personal property of the individual admitted to the residential program for care.

520.1 The provider must have a written plan describing how emergency medical and dental care services are provided to individuals served in the residential program(s).

520.2 The provider must maintain updated written documentation that individuals served in its residential program(s) have varied, well-balanced meals at least three (3) times daily, seven (7) days per week. Special diets must be provided for individuals needing special consideration, when documented by a physician.

520.3 The provider must document that each individual served in its residential program(s) is provided with orientation that includes, at a minimum:

a. An explanation of the program's services, activities, performance expectations, and rules and regulations (a copy of such rules and regulations must be provided to the individual);

b. An explanation and provision of a written copy of rights of individuals served by the program;

c. Familiarization of the individual with the living arrangement and neighborhood; and

d. An introduction to support staff and to other individuals.

PART VIII

EMERGENCY/CRISIS SERVICES

VIII.ECS. Emergency/Crisis Services are those designated for immediate intervention(s) available to individuals experiencing personal crisis. Emergency/Crisis Services are included in the minimum required services that must be provided by entities certified as DMH/C. Emergency/Crisis Services must be made available by providers designated as DMH/C to the following populations: adults, children, youth, and individuals with intellectual/ developmental disabilities.

SECTION A – EMERGENCY/CRISIS SERVICES

VIII.A.1. Emergency/Crisis Services are time-limited interventions, available twenty-four (24) hours a day, seven (7) days per week. When needed, trained emergency/crisis response staff triage referrals and respond in a timely and adequate manner to diffuse the current personal crisis situation. A crisis situation is defined as a situation in which an individual's mental health and/or behavioral needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation. Program staff must be able to triage and make appropriate clinical decisions, including accessing the need for inpatient services or less restrictive alternatives.

VIII.A.2. The expected outcomes of emergency/crisis services include:

a. Individuals have access to face to face contact 24/7 (see VIII.A.5. below).
b. Providers certified as DMH/C must have documented formal agreements (or denial of agreements) with every emergency room in the CMHC catchment area.
c. Training regarding the handling of mental health related emergencies/crises is provided to identified emergency personnel.
d. Individuals are provided alternatives to hospitalization.
e. Individuals' reliance on inpatient hospitalization will decrease.

VIII.A.3. Emergency/Crisis Services must be made available in every county/area served by the provider.

VIII.A.4. Recipients of Emergency/Crisis Services are not required to be already established consumers of services provided by the community mental health center.

VIII.A.5. The provider must ensure that a mental health representative is available to speak with an individual in crisis and/or family members/legal guardians of the individual twenty-four (24) hours a day, seven (7) days a week. An accessible toll free number must be made available for this purpose. Individuals in crisis should only have to dial one

number for assistance. Answering services are permissible as long as the individual speaks with a trained professional. Answering machines are not permissible.

VIII.A.6. 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. This individual is not required to see the individual in their home (however this is permissible), but there must be designated, strategic, publicized locations that the person can be seen. The individual must be seen within one (1) hour of initial time of contact for those in urban settings and within two (2) hours of initial time of contact for those in rural settings.

VIII.A.7. Appointments for individuals in crisis that can be resolved over the telephone must be provided the next day, twenty-four (24) hours a day, seven (7) days a week.

VIII.A.8. Assessment and treatment to individuals held in jail waiting inpatient commitment must be provided twenty-four (24) hours a day, seven (7) days a week.

VIII.A.9. All persons involved in the provision of emergency services must be provided training in the handling of mental health emergencies and crisis intervention.

VIII.A.10. There must be documentation that all staff assigned to emergency/crisis services are trained in the policies and procedures required for pre-evaluation screening and civil commitment.

VIII.A.11. The provider must annually have current written interagency agreement(s) or contract(s) with licensed hospitals to provide emergency room services that at a minimum address the following:

e. Training of emergency room staff in handling mental health emergencies;

f. Availability of hospital emergency room services to address the needs of individuals in crisis;

g. Availability of face-to-face contact with a mental health professional; and

h. 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.

VIII.A.12. If a DMH-certified Crisis Stabilization Unit is available in the area, the provider must annually have current written interagency agreement(s) or contract(s) with the Crisis Stabilization Unit for assessment twenty-four (24) hours a day, seven (7) days a week.

VIII.A.13. Emergency/Crisis service availability must be publicized, including a listing in the telephone directories for the area served by the program.

VIII.A.14. Providers of emergency/crisis services must maintain a written, daily log of emergency/crisis face-to-face and telephone contacts, including, at a minimum:

a. Identification of individuals involved in the emergency/crisis;

b. Time and date contact to the provider was initiated by the individual and/or family member/legal guardian.

c. Time and date that emergency face-to-face contact and/or telephone contact;

d. If face-to-face contact was made, identification of location of contact;

e. Presenting problem(s);

f. Action(s) taken by emergency services staff;

g. Documentation of notification and involvement of significant others, and when contact is deemed inappropriate, indication of why notification was not made.

h. Disposition or resolution of the emergency/crisis, including:

(1) Condition of the individual(s) at the last face-to-face contact and/or termination of the telephone call; and,

(2) Services to which the individual and/or family was referred.

j. Name and position of staff member(s) addressing the emergency/crisis.

PART IX

CASE MANAGEMENT SERVICES

IX.CM. Case Management Services are included in the minimum required services that must be provided by entities certified as DMH/C. Case Management Services must be made available by providers designated as DMH/C to the following populations: adults with serious mental illness, children/youth with serious emotional disturbance, and individuals with intellectual/developmental disabilities. Additionally, School Based Services, Mental Illness Management Services and Individual Therapeutic Support Services are considered types of case management services.

SECTION A- GENERAL CASE MANAGEMENT SERVICES

IX.A.1. Case Management is the provision and coordination of services that are an integral part of helping individuals access needed medical, social, educational, and other services in order to attain their highest level of independent functioning. Activities include individual's identification, assessment, reassessment, service planning, referral, service delivery monitoring, and supportive counseling as well as outreach services designed to seek out and engage persons who are for eligible for case management.

IX.A.2. The expected outcomes of case management services include:

a. Individuals return to their highest level of functioning.
b. Individuals achieve community inclusion and service goals through linkage to service and natural supports.
c. Individuals decrease their need for services.

IX.A.3. The following individuals with serious mental illness and children/youth with serious emotional disturbance must be evaluated for the need of case management and provided case management, if needed based on the evaluation, unless the service has been rejected in writing by the individual evaluated.

a. Adults who have a serious mental illness or children/youth with serious emotional disturbance and receive substantial public assistance. (public assistance is defined Medicaid);

b. Adults with serious mental illness referred to the community mental health center after discharge from an inpatient psychiatric facility;

c. Children/youth with a serious emotional disturbance who are receiving intensive crisis intervention services; and

e. Children/youth with a serious emotional disturbance referred to the community mental health center after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes (within two weeks of referral for community mental health services).

IX.A.4. Case management must be offered to individuals with serious mental illness, intellectual disabilities/developmental disabilities, legal guardians of youth with serious emotional disturbance at a minimum, every twelve (12) months. Refusals of services must be documented in writing.

IX.A.5. The provider must document involvement of the individual's family in case management services when appropriate.

IX.A.6. Providers of case management services must at a minimum:

a. Have an established case management unit with a full-time Director of Case Management Services;

b. Assign a full time, DMH certified case manager for each individual enrolled in case management;

c. Maintain a list of each case manager's case load that must be available for review by DMH staff;

d. Maintain a current, comprehensive file of available community resources that is readily accessible to all case mangers. This resource file must include at a minimum:

(1) Name of agency;
(2) Eligibility requirements;
(3) Contact person;
(4) Services available; and,
(5) Phone number of the resource agency.

IX.A.7. Individuals receiving case management services with whom no contact has been reported for twelve (12) months must be closed after a documented effort has been made to contact the individual.

SECTION B- ADULT SMI CASE MANAGEMENT

IX.B. In addition to meeting the standards outlined in Section A– General Case Management Services, providers of Adult SMI Case Management Services must also meet the standards outlined in this section.

IX.B.1. The provider must develop an annual written plan for providing case management services that must include, at a minimum, the following areas:

a. Identification of the target population as established in case management guidelines;

b. Specific strategies to be used for outreach to the target population;

c. Formal and informal linkage and coordination efforts with appropriate services in the community, including referral process;

d. Monitoring and follow-up.

IX.B.2. The case management program must have implemented written policies and procedures assuring that individuals being discharged from inpatient psychiatric care are provided an evaluation to determine the need for case management services within two weeks of referral to community services.

IX.B.3. Providers must adhere to the following Case Load Options:

a. Option 1 – Regular case load, maximum of forty (40) individuals;

b. Option 2 – Combination of regular and follow-along, maximum of sixty (60) individuals to be composed of no more than twenty (20) regular and forty (40) follow-along,

c. Option 3 – Follow-along only, maximum of eighty (80) individuals.

IX.B.4. Providers must utilize the following framework to support the frequency of case management contacts:

a. High – at least once every seven (7) days;

b. Moderate – at least twice every fourteen (14) days;

c. Low – at least once every thirty (30) days; and

d. Follow Along – at lease once every ninety (90) days.

IX.B.5. The service plan must clearly state and justify the frequency of contact.

SECTION C- CHILDREN/YOUTH CASE MANAGEMENT SERVICES

IX.C. In addition to meeting the standards outlined in Section A– General Case Management Services, providers of Children/Youth Case Management Services must also meet the standards outlined in this section.

IX.C.1. Efforts to obtain input into the development of the case management service plan(s) of youth enrolled in case management from the following representatives must be documented:

c. Representative(s) of the Mississippi Department of Human Services (DHS) for children/youth in DHS custody our under their supervision;

d. Representative(s) of the child's/youth's local school.

IX.C.2. Input of the parents in the development of the case management service plan from parent(s)/legal guardian(s) of youth enrolled in case management must be documented.

IX.C.3. The written policy and procedure manual for the operation of case management services must also include the following areas:

c. Specific strategies to be used for outreach to the target population for case management services;

d. Formal and informal linkages and coordination efforts with appropriate services in the community, including referral process(es).

IX.C.4. Parent(s)/legal guardian(s) of children/youth being discharged from public inpatient psychiatric care must be offered an evaluation to determine the need for case management services within two weeks after referral for community services.

IX.C.5. The case load for a single case manager must not exceed fifty (50), this includes combined case loads of SMI/SED.

SECTION D- INTELLECTUAL/DEVELOPMENTAL DISABILITIES CASE MANAGEMENT SERVICES

IX.D In addition to meeting the standards outlined in Section A– General Case Management Services, providers of Intellectual/Developmental Disabilities Case Management Services must also meet the standards outlined in this section.

IX.D.1. Face-to-face contact must, at a minimum, be conducted on an annual basis with each individual receiving service.

IX.D.2. Providers must adhere to the following Case Load Options:

a. Option 1 – High- maximum of forty (40) individuals;

b. Option 2 – Moderate – maximum of sixty (60) individuals;

c. Option 3 – Low – maximum of eighty (80) individuals;

d. Option 4 – Combination – Maximum of fifty (50) individuals.

IX.D.3. Providers must utilize the following framework to support the frequency of case management contacts:

a. High- one to four times a month;

b. Moderate – once a month to once a quarter;

c. Low – once a quarter to once a year.

IX.D.4. Potential/Temporary Case Management Services should be provided to individuals while they are in the process of being enrolled into permanent case management or to individuals who do not need ongoing case management but have an immediate need for a service. Potential/Temporary Case Management Services can not exceed 120 calendar days.

PART X

PSYCHOSOCIAL PROGRAMS

Psychosocial Rehabilitation Services are therapeutic activity programs provided in the context of a therapeutic milieu in which individuals can address personal and interpersonal issues with the aim of achieving/maintaining their highest possible levels of independence in daily life. Psychosocial Services include: Psychosocial Rehabilitation/Clubhouse Services, Senior Psychosocial Rehabilitation, Day Support, and Day Treatment Services.

SECTION A- PSYCHOSOCIAL REHABILITATION/CLUBHOUSE SERVICES

X.A.1. Psychosocial Rehabilitation/Clubhouse is a community support service for people with serious mental illness which consists of a network of services that help the service recipient develop the potential to live independently and/or become employed. Psychosocial rehabilitation/clubhouse is a program of structured activities designed to support and enhance the role functioning of individuals with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental 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, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

X.A.2. Expected outcomes of Clubhouse Services include:

a. Individuals served will remain in the community setting.
b. Individuals' reliance on inpatient hospitalization will be reduced.
c. Individuals' reality orientation, social adaptation, physical coordination, daily living skills, time/resource management and task completion skills of individuals will improve.
d. Individuals' psychiatric symptoms such as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth will be alleviated.
e. Individuals will receive employment training and opportunities of their choosing.
f. Individuals will transition back into the community to achieve and maintain their highest level of recovery.

X.A.3. The program must operate in one location for a minimum of four (4) hours per day, four (4) days per week, excluding travel time.

X.A.4. A Psychosocial Rehabilitation/Clubhouse program must have an annual average daily attendance of more than eight (8) individuals.

X.A.5. All activities of the program must be established around a day which is structured by task activity units. The units provide all individuals an opportunity to participate.

X.A.6. There must be a minimum of two (2) task activity units, which can include but not be limited to:

a. Clerical unit;

b. Kitchen unit;

c. Snack bar unit;

e. Gardening unit.

X.A.7. Transitional and other employment opportunities must be an integral part of the Psychosocial Rehabilitation/Clubhouse service and must be made available to at least 10% of the number of individuals the program is certified to serve. A minimum of one (1) transitional employment placement must be available in a competitive employment setting in the community in which individuals without disabilities are also employed and that is not operated by the provider program.

X.A.8. Recreational and/or social activities must not be conducted during the structured program hours.

X.A.9. The program must have its own identity, including its own name.

X.A.10. The program is to be located in its own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other programs during hours of program operation. The clubhouse is to be designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.

X.A.11. All program space must be accessible to both individuals receiving services and staff. There are to be no "staff-only" or "individual-only" spaces.

X.A.12. The program site must have sufficient space to accommodate the full range of program activities and services and must provide at least fifty (50) square feet of multipurpose space for each indivdiual.

X.A.13. The Psychosocial Rehabilitation/Clubhouse staff must include at each site a full time supervisor (as defined in Standard VI.C.1(c)) who plans, coordinates, and evaluates the psychosocial rehabilitation program.

X.A.14. Psychosocial Rehabilitation/Clubhouse programs must maintain a minimum of one qualified staff member to each eight (8) or fewer individuals the program is certified to serve.

X.A.15. There must be, on file, a written plan and a description of the service that must include but not be limited to the following:

a. The purpose, goals, and objectives;

b. The population to be served, including the number of individuals to be served by location;

c. The physical environment surrounding the program, at each site;

d. Mechanisms to be used to establish members as decision makers in the operation of the service;

e. Plan for developing and maintaining transitional employment placements.

X.A.16. The program must maintain an evaluation system which addresses at a minimum:

a. Total number of members on roll;

b. Daily attendance;

c. Annual attendance by subgroups (age, sex, race);

d. Average length of stay;

e. Reasons for leaving the program (recidivism vs. progression toward community integration);

f. Member satisfaction with psychosocial services;

g. The number and type of transitional employment jobs;

h. The number of individuals participating in transitional employment;

i. The number of hours available in the transitional employment program by placement;

j. The number of hours worked and income earned by each individual participating in the transitional employment program;

k. Degree of individual involvement in decision making.

X.A.17. Individuals must have a method defined by policy and procedures to communicate their desires to the director of the psychosocial/clubhouse and to the Executive Director of the program, and there must be documentation of such communication on site.

X.A.18. Individuals must have the opportunity to participate in all the work of the clubhouse, including orientation, outreach, training, hiring, and evaluation of staff, or documentation requirements.

SECTION D- DAY TREATMENT SERVICES

X.D.1. Day Treatment is the most intensive outpatient program available to children and adolescents. It should provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides children/adolescents with serious emotional/behavioral disturbances and/or intellectual/developmental disabilities the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants in a particular program and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

X.D.2. Expected outcomes of Day Treatment Services include:

a. Individuals served in Day Treatment programs will transition to a less intensive therapeutic service and/or environment.
b. Individuals served in Day Treatment programs will transition to the regular classroom setting.

The Standards that follow pertain to ALL providers of Day Treatment Services.

X.D.3. Individuals being served must meet all requirements which determine the eligibility for the services being provided.

a. Criteria for the following must be met: Serious Emotional Disturbance, Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Alcohol and Drug Addiction/Abuse, Intellectual/Developmental Disabilities.

b. Justification of the need for Day Treatment services, including intensity and duration of problems, must be documented as part of the intake/assessment or as part of a post-intake case staffing and annually thereafter. Documentation must 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.

X.D.4. At a minimum, one (1) children's Day Treatment Program must be available at a school site in each school district in the region served by a Community Mental Health Center.

X.D.5. Each 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 must receive Day Treatment services 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.

X.D.6. To ensure each child's confidentiality, no children other than those enrolled in the Day Treatment Program can be present in the room during the time Day Treatment is being provided.

X.D.7. Only one (1) Day Treatment Program is allowed per room during the same time period.

X.D.8. Each Day Treatment Program must operate under separate DMH Certificates of Operation.

X.D.9. The Day Treatment Program Director (as defined standard VI.C.1(a)) or their designee (as approved by the DMH) must supervise, plan, coordinate, and evaluate Day Treatment services. Supervision must be provided at least one continuous hour per month. In addition, the Day Treatment Program Director or their designee must provide at least 30 continuous minutes of direct observation to each Day Treatment Program quarterly**.** Documentation of the supervision/observation must be maintained for review.

X.D.10. The DMH Division of Accreditation and Licensure must be notified immediately of any interruption of service with a Day Treatment Program extending over thirty (30) days. If operation has been interrupted for sixty (60) calendar days, the DMH Certificate of Operation must be returned to the DMH Division of Accreditation and Licensure.

X.D.11. Day Treatment Programs are intended to operate year-round and can not be designed to operate solely during the summer months.

X.D.12. Day Treatment Programs that are unable to provide school-based services during a school's summer vacation will be allowed to hold that program's Certificate of Operation until the program 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 Accreditation and Licensure.

X.D.13. Day Treatment Programs that do not meet during summer vacation must offer services for the child/youth to the parent(s)/legal guardian(s) for the period that the Day

Treatment Program is temporarily not operational. Documentation must be maintained that availability of other services was explained and offered to the parent(s)/legal guardian(s).

X.D.14. Day Treatment Programs operated in a school must ensure that Day Treatment Services continue to adhere to all DMH Operational Standards for MH/IDD/SA Community 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 conducted concurrently.

X.D.15. 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 should 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 individual's comprehensive Individual Service Plan.

X.D.16. Each Day Treatment Program must operate at any one time with a minimum of four (4) and a maximum of nine (9) children/youth. A Day Treatment roll/roster can not exceed nine (9) children/youth per Program.

X.D.17. Each Day Treatment Program (four to nine children) 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 of individuals receiving services must be listed for all individuals participating in each skill area (time period) being addressed.

X.D.18. Each Day Treatment Program must comply with the following:

a. A minimum of twenty square feet of usable space per child;

b. In cases of school-based programs, the mental health provider is responsible for ensuring that the school district provides a site or facility that meets all standards in Part VII - Environment/Safety. 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.

c. Furnishings, equipment, square footage and other aspects of the Day Treatment environment must be age-appropriate, developmentally appropriate, and therapeutic in nature.

X.D.19. The ratio of staff to individuals 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 nine (9) children/youth per program. The program must be led by a Day Treatment Specialist (as defined in Standard VI.C.1(j)). Day Treatment Assistants (as defined in Standard VI.C.1(p)) serve as the second needed staff in this ratio.

X.D.20. Transitional procedures must be included in the Individual Service Planning for all children/youth participating in Day Treatment Programs. Documentation of plans for transitioning a child to a less intensive therapeutic service when deemed clinically appropriate must be maintained in each child's record.

Day Treatment Services for Children/Youth with Intellectual /Developmental Disabilities

X.D.21. In addition to meeting all requirements and standards included in Section D (Standards X.D.1 through X.D.21.), providers of Day Treatment to children/youth with Intellectual or Developmental Disabilities must document the justification of the need for Day Treatment services for children with ID/DD as part of the intake/assessment. Documentation must include, at a minimum; Psychological Testing, ID/DD Eligibility Certificate. There must also be an Individual Education Plan for school aged children that directly relates to the Individual Service Plan.

Day Treatment Services for Children/Youth with Alcohol and/or Drug Dependence or Abuse

X.D.22. In addition to meeting all requirements and standards included in Section D (Standards # X.D.1 through X.D.21), providers of Day Treatment to children/youth with alcohol and/or drug dependence or abuse must:

a. Operate for at least ten (10) weeks for each adolescent.

Day Treatment Services for Pre-K

X.D.23. 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. These standards are in addition to the previous standards required for all day treatment programs.

X.D.24. All children must be signed in and out of the program by a parent/legal guardian. If child is being transported by the program staff, the parent/legal guardian must sign the child on and off of the van. The parent/legal guardian 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 guardian, written permission from the parent/legal guardian must be in the child's chart. Sign In/Out documentation must be available for review.

X.D.25. Chairs and tables used in the day treatment room must be appropriate to the size and age of the children. This furniture must be kept clean with frequent disinfection.

X.D.26. 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.

X.D.27. All children participating in day treatment must be age appropriately immunized and must have, on file, a Certificate of Immunization Compliance (MSDH Form 121) that has been signed by the District Health Officer, a physician, nurse or designee.

X.D.28. Any child who is suspected of having a contagious condition must be removed from the day treatment room and returned to the parent/legal guardian as soon as possible. The child will not be allowed to return to the day treatment room until they have been certified by a physician to no longer be contagious. Conditions that would require exclusion from the program include fever, diarrhea, vomiting, rash, and sore throat if accompanied by a fever and eye discharge.

X.D.29. 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.

PART XI

COMMUNITY LIVING

Community Living Services encompass any type of provider offered living arrangements and/or services. There are three core types of Community Living Services: Supported

Living, Supervised Living and Residential Treatment. The level/type of service is dependent upon the needs of the individuals in the service.

SECTION A- TYPES OF COMMUNITY LIVING SERVICES

XI.A.1. Supported Living. The provider has necessary staff to support the individual in the community who needs less than twenty-four (24) hours per day/seven (7) days per week support. Supported Living is the most integrated community living service available. Services offered under Supported Living include:

d. Home and Community Supports (HCS). These services are available to individuals with Intellectual/Developmental Disabilities participating in the ID/DD Waiver. *(This service was referred to as ID/DD Waiver Attendant Care Services and ID/DD Waiver Supported Living in the 2002 DMH Standards.)*

e. Therapeutic Foster Care (TFC). These services are only available to children/youth with serious emotional disturbance.

f. Supported Housing. Supported Housing services are available to adults with serious mental illness and individuals with Intellectual/Developmental Disabilities who do not participate in the ID/DD Waiver program. *(This service was referred to as IDD Supported Living and MH Supervised Housing.)*

XI.A.2. Supervised Living. The provider has necessary resources to support the individual in the community with twenty-four (24) hour/seven (7) days per week staffing coverage. Supervised Living is an intermediate level of community living service that is available. Services offered under Supervised Living include:

f. Supervised Living. This service is available to individuals with Intellectual and/or Developmental Disabilities.

g. Therapeutic Group Homes (TGH). This service is available to children/youth with serious emotional disturbance.

h. Transitional Residential. This service is available to individuals seeking Substance Abuse Prevention and Rehabilitation services.

i. Halfway House. This service is available to adults with serious mental illness.

j. Group Homes. This service is available to adults with serious mental illness.

XI.A.3. Residential Treatment. The provider has necessary resources to support the individual's treatment twenty-four (24) hours a day/seven (7) days per week with staffing coverage. The individual also remains on site twenty-four (24)/seven (7) (except school hours for C&Y). This is the most restrictive level of care available in the community.

e. Crisis Residential. This service is available to children and youth with serious emotional disturbance.

f. Chemical Dependency Units. This service is available to individuals seeking Substance Abuse Prevention and Rehabilitation Services.

g. Primary Residential. This service is available to individuals seeking Substance Abuse Prevention and Rehabilitation Services.

h. Crisis Stabilization Units (CSU). This service is available to adults with serious mental illness.

SECTION B- PROGRAM MANUALS

XI.B.1. All providers of Community Living Services (all types) must develop a program manual which includes all policies and procedures of the service. The program manual must be on-site and updated as needed. At a minimum, the program manual must address the following:

e. A definition of the service being provided;

f. The philosophy, purpose and overall goals of the service, to include but are not limited to:

(1) Method for accomplishing stated goals and objectives.
(2) Expected results/outcomes.
(3) Methods to evaluated expected results/outcomes.

g. Admission to the services;

h. Description of the program's components or services, including the minimum levels of staffing required for the protection and guidance of individuals to be served in the program;

e. A description of therapeutic modalities and treatment activities (including age-appropriate activities) to be provided (if any) and a schedule of these activities;

f. A description of the meals and snacks to be provided, to include but not limited to;

(1) Development of menu (with residents input);
(2) Insurance of varied, nutritious meals and snacks; and
(3) Preparation of meals and snacks.

g. A description of the program rules, to include but not limited to;

(1) Visitation (including restricted visitors);
(2) Communication (phone, mail, email, etc.);
(3) Dating;
(4) Off-site Activities;
(5) Household Tasks;
(6) Curfew;
(7) Use of Alcohol, Tobacco and other Drugs; and
(8) Respecting the rights of other residents' privacy, safety, health and choices.

h. Collection of fees, to include but not limited to;

(1) Basic charges;
(2) Time frame covered by charges;
(3) Special service charges;
(4) Refund of charges/deposits; and
(5) Written financial agreement.

i. Room, person and/or possession searches, 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.

j. Prohibited substance screening, 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.

k. Orientation to Community Living services, to include but not limited to;

(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.); and
(4) Description of the process for informing individuals/parents/guardians of their rights, responsibilities and any applicable program rules prior to or at the time of admission.

l. Routine and emergency medical and dental care, to include but not limited to;

(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.

m. Responsibility of the staff for implementing the protection of the individual and his/her personal property and rights;

n. The need for and development, implementation and supervision of behavior change/management programs;

o. Risk assessment and mitigation;

p. Personal hygiene care and grooming;

q. Prevention of and protection from infection, including communicable diseases;

r. Medication management; and

t. Discharge criteria.

XI.B.2. A pet policy must be addressed in the agency's policy and procedures manual and program manual for all providers/programs that maintain animals on their property. The policy must address, at a minimum, the following:

a. Pets must be vaccinated again rabies and all other diseases communicable to humans (vaccination records must be maintained on site).

b. Pets must be kept in a sanitary manner and away from food preparation sites or eating areas.

c. Pets must be controlled to prevent injury of individuals receiving services, staff, or visitors.

SECTION C- SPECIFIC REQUIREMENTS FOR COMMUNITY LIVING SERVICES FOR CHILDREN AND YOUTH

XI.C.1. Each child/youth 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.

XI.C.2. All Community Living programs for children and youth 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:

a. Social skills development;
b. Anger management;
c. Wellness education;
d. Increasing self-esteem;
e. Leisure activities;
f. Substance abuse education/counseling;
g. HIV/AIDS education and/or counseling; and
h. Sexually Transmitted Diseases.

XI.C.3. The provider must maintain updated daily and weekly schedule(s) of activities that reflect group activities and routines, as well as individually planned activities for the children and youth served in the Community Living program. Daily and weekly schedule(s) of activities must be maintained on file for at least three (3) months. Group activities must be related to implementation of objectives in the Individual Service Plans of children and youth served in the program.

XI.C.4. The program must obtain a permission form, signed by the parent or legal guardian, for the child/youth to participate in specific program activities off the program site.

XI.C.5. Children/youth must have a dental examination within sixty (60) days after admission and annually thereafter. Evidence of a dental examination within the twelve (12) months prior to admission may take the place of a dental examination within sixty (60) days after admission.

SECTION D- HANDBOOK REQUIREMENTS

XI.D.1. All providers of Community Living Services (all types) must develop a handbook to be provided to the individual/parent/guardian during orientation which must address at a minimum the following:

a. An explanation of the services, activities, performance expectations, substance use (including alcohol) policy and any other rules and regulations;

b. An explanation of the rights of individuals served by the program; and

c. An explanation of the program's policies regarding respecting the rights of other residents' privacy, safety, health and choices;

d. An explanation of any fees and how the fees are collected;

e. An explanation of the circumstances for an individual's room, person and/or possessions to be searched;

f. An explanation of the circumstances for an individual to be required a prohibited substance screen, the consequences of a positive screening for prohibited substances and the consequences of refusing a prohibited substance screen;

g. An explanation of routine and emergency medical and dental treatment;

h. An explanation of educational and vocational opportunities; and

ii. Review of visitors, callers, relatives, or others who are identified as required "no contact" or counter therapeutic with the resident.

j. For provider of Children/Youth Community Living Services, policies and procedures regarding dating, description of out of facility activities, and the expectations regarding participation of parents/legal guardians in treatment.

XI.D.2. All providers of Community Living Services (all types) must comply, at a minimum, with the following:

a. The provider 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; and

c. The provider must document input from residents regarding the development of all sections of the handbook.

SECTION E- FEE AGREEMENTS

XI.E.1. A written financial agreement in Community Living Services where individuals served pay rent/utilities which must, at a minimum address the following;

a. Include written procedures for setting and collecting fees (in accordance with Standard III.FM.2.);

b. Include a detailed description of the basic charges agreed upon (ex: rent, utilities, food, etc.);

c. Indicate the time period covered by the charges;

d. List the services for which special charges are made;

e. Contain written documentation of the explanation and review with the individual/ parent/legal guardian prior to or at the time of admission and annually thereafter;

f. Contain the signature of the individual and/or legal guardian to indicate agreement with its contents;

g. Be maintained in each person's record, with a copy of the signed agreement provided to the individual/legal representative; and

i. Be reviewed/revised at least annually or as changes occur.

SECTION F- DISCHARGE REQUIREMENTS

XI.F.1. All providers of Community Living Services (all types) must develop policies and procedures for discharge or termination from the service/program which must, at a minimum, address the following;

a. Reason for discharge;

b. Assessment of progress toward Individual Service Plan or Service/Activity Plan, Needs Assessment/Aftercare Plan or Plan of Care objectives;

c. Discharge instructions given to the individual who received services or their authorized representative, parent(s)/legal guardian(s), including referrals made;

d. Any other information deemed appropriate to address the needs of the individual being discharged from the program.

XI.F.2. Providers of Community Living Services for Children and Youth, must have implemented policies and procedures that ensure that, at a minimum:

a. Children and youth being discharged from services back to placement in the community are given an appointment with a psychiatrist within four (4) weeks after discharge. Discharge can not take place until appointment has been secured;

b. The child/youth (and family member(s) as appropriate) are evaluated for and/or enrolled in case management services within two (2) weeks after referral for community services; and

c. For children and youth in the custody of the MS Department of Human Services, the social worker from the county of residence of the child/youth is provided the opportunity to be in involved in the discharge/placement plans;

d. For children and youth in the custody of the MS Department of Human Services, the child/youth is provided an opportunity for one pre-placement visit prior to discharge.

e. Document that an appointment has been scheduled with the CMHC responsible for services in the county where the youth will reside upon discharge.

SECTION G- SUPPORTED LIVING OPTIONS

Supported Living Options include: Home and Community Supports (HCS), Therapeutic Foster Care Programs for children/youth who have a serious emotional disturbance, Supported Housing Services for adults with serious mental illness and individuals with intellectual/ developmental disabilities.

Home and Community Supports for individuals participating in the ID/DD Waiver Program

XI.G.1. Home and Community Supports offer a range of services for participants who require assistance to meet their daily living needs, ensure adequate functioning in their home and community, and provide safe access to the community.

XI.G.2. Expected outcome of Home and Community Supports is that people receive the services and supports necessary to remain at home and in the community.

XI.G.3. HCS must consist of one or more of the following types of services, depending on each individuals identified needs:

a. Activities of daily living (ranging from total support in these activities to partial physical support to prompting);

b. Assistance in housekeeping directly related to the individual's health and welfare;

c. Assistance with the use of adaptive equipment; and

d. Support and assistance for community participation, including appointments, banking, shopping, recreation/leisure activities, socialization opportunities.

XI.G.4. HCS cannot be provided in schools or be a substitute for educational services or other day services for which the individual is appropriate (e.g., Day Services-Adults, Prevocational Services, Supported Employment, and/or Work Activity Services).

XI.G.5. 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.

XI.G.6. HCS staff cannot accompany a minor on a medical visit without a parent/legal guardian.

XI.G.7. HCS providers are not permitted to provide medical treatment as defined in MS Nurse Practice Act.

XI.G.8. HCS providers may assist individuals with money management, but cannot receive or disburse funds on the part of the participant. Individuals must maintain their own financial resources according to the following:

a. No staff or agency name can appear on an individual's personal accounts; and

b. No financial transaction can be made if the individual is not present.

Therapeutic Foster Care Programs

XI.G.9. Therapeutic Foster Care (TFC) is an intensive community-based program composed of mental health professional staff and trained foster parents who provide a therapeutic program for children and youth with serious emotional disturbances living in a foster home.

XI.G.10. The expected outcomes of therapeutic foster care programs include:

e. Children/youth in TFC experience an increase in the number of stable placements.

f. Each child/youth in the program has increased biological or adoptive parental involvement in Individual Service Planning and participation in the program in order to promote success of the child/youth's permanency plan.

g. Each child/youth receives needed services and supports through collaboration with other agencies that provide services to children/youth.

XI.G.11. Each therapeutic foster 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 TFC home if the following conditions apply:

e. The siblings have never been separated;

f. The siblings are not a danger to others;

g. The DMH has approved in writing the siblings may be placed together in the same TFC home. This documentation must be maintained in the individual case record of each sibling; and

h. TFC parents asked to place siblings in their home must consent to the placement in writing. This documentation must be maintained in the individual case record of each sibling.

XI.G.12. Each TFC program certified for ten (10) to thirty (30) homes must have a full-time director with overall administrative and supervisory responsibility for the program. If the TFC program is certified for less than ten (10) homes, the director can have administrative or supervisory responsibility for other 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 program.

XI.G.13. Each TFC program certified for ten (10) to thirty (30) homes must have one full-time TFC specialist whose services target the TFC families. The TFC specialist's specific responsibilities must include at least the following:

a. Recruitment and training of therapeutic foster parents;

b. Conducting interviews and other necessary work to appropriately place individual children and youth with prospective therapeutic foster parents;

c. Maintenance of regular contact with TFC families and provide documentation of those contacts in the case records; and,

h. Performance of other family support activities, as needed.

XI.G.14. If the TFC program is certified for less than ten (10) 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 is spent in performing duties of the TFC specialist/case manager. (For example, in a program with two (2) therapeutic foster homes, at least twenty percent (20%) of the assigned staff's time must be spent in performing duties of the therapeutic foster case specialist.)

XI.G.15. TFC programs must provide or contract with a community mental health center or a private practitioner to provide mental health therapeutic services for all children/youth in the program. These services must include individual and family therapy. Group therapy may also be provided.

XI.G.16. A licensed psychiatrist with experience working with children/youth, on an employment or contractual basis must be available for youth served by the TFC.

XI.G.17. Each TFC program must utilize adults with current documentation of foster parent approval by the Mississippi Department of Human Services.

XI.G.18. Each TFC program must have one (1) full-time professionally licensed or DMH credentialed mental health therapist for every twenty (20) therapeutic foster children/youth in the TFC program.

XI.G.19. The mental health therapist(s) for the TFC program must serve only in the mental health therapist role (i.e. cannot serve as the director or the TFC specialist).

XI.G.20. Arrangements must be made for and documentation maintained in the record for children/youth to have a physical examination within thirty (30) days after admission, and annually thereafter.

XI.G.21. Arrangements must be made for and documentation maintained in the record for children/youth to have a psychological or psychiatric evaluation at least annually.

XI.G.22. The mental health therapist must have at least one individual therapy session per week is required with the child or youth. At least one family session per month is required with the foster parent(s).

XI.G.23. The TFC specialist must have face-to-face contact with each TFC parent(s) at least two times per month, with at least one of the two contacts made during a home visit. All TFC program contacts of the TFC specialist with the TFC parent(s) must be documented in the individual case record of the parent(s).

Supported Housing Services

XI.G.24. Supported Housing is a form of housing service that provides a residence for three (3) or fewer individuals in a single living unit. Individuals function with a greater degree of independence than in a supervised living environment. Supported Housing generally has staff responsible for the housing unit. Contacts with the individual are needed on a regular basis of at least several times a month. During the day individuals may engage in activities of the provider program, supported or transitional employment, competitive employment, or other community activities.

XI.G.25. The expected outcome for Supported Housing Services is that individuals gain greater self-sufficiency and move into the most integrated setting in the community, based on their level of needed support.

XI.G.26. If the housing unit is owned and/or operated by the provider, then each housing unit must have:

a. A fire extinguisher that is securely mounted in the kitchen. This fire extinguisher must be regularly checked by staff and must be inspected at least annually to assure that it is operable;

b. Providers must provide evidence that fire extinguishers are being recharged after 6 years;

c. 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

d. 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.

XI.G.27. Training must be provided to adults receiving any type of Supported Housing Services (whether or not the housing unit is owned/operated by the provider) which includes, but not limited to, the following;

a. The PASS (Pull, Aim, Squeeze, Sweep) method of using a fire extinguisher. If necessary, staff must assist in obtaining and mounting fire extinguisher;

b. 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;

d. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature; and

e. Any other health/safety issues based on the needs of each resident.

XI.G.28. Providers who serve individuals who live alone must have at least one (1) qualified staff person on call twenty-four (24) hours per day/seven (7) days per week, in case of emergency and/or to manage unplanned needs which may arise for the individual(s).

XI.G.29. Providers must develop methods, procedures and activities to provide independent living choices for the individual(s).

XI.G.30. Procedures must be developed for individual(s) to access any other needed services in the event of an emergency.

XI.G.31. To the degree possible, the residents must have the authority and responsibility to operate the housing unit as they see fit.

XI.G.32. The Supported Housing activities and physical arrangement must be designed to promote individual independence and encourage independent living.

XI.G.33. The provider must have a method to determine individual satisfaction with the service. This evaluation must include, at a minimum, the satisfaction with location and upkeep of the apartment/residence, the support provided in achieving independence, accessibility to community resources and services, and the ability to make independent decisions. This evaluation must be conducted at least annually, with results on file for review.

XI.G.34. Support must be available as needed to provide:

a. Money management training;

e. Independent living skills training and support;

f. Community resources training and support; and

g. Access to mental health, IDD, health, and other community services.

SECTION H- SPECIFIC REQUIREMENTS FOR ALL SUPERVISED LIVING & RESIDENTIAL TREATMENT PROGRAM OPTIONS

XI.H.1. This section applies to environmental and programmatic requirements that are specific to all Supervised Living and Residential Treatment Program options.

XI.H.2. Bedrooms must meet the following specifications:

a. 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;

b. Resident bedrooms must meet the following dimension requirements:

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

c. Resident bedrooms must house no more than three (3) persons each;

d. 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;

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

f. Single 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;

g. 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;

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. 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 place in a central location outside of sleeping areas.

j. Each bedroom must have at least two means of escape; and

l. 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.

XI.H.3. All providers must ensure that programs have furnishings that are safe, comfortable, appropriate, and adequate.

XI.H.4. 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.

XI.H.5. 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.

XI.H.6. All programs must ensure visiting areas are provided for residents and visitors:

a. Facilities housing less than thirteen (13) residents must have at least one (1) visiting area;
b. Facilities housing thirteen (13) or more persons must have two (2) visiting areas; and
c. Each visiting area must have at least two (2) means of escape.

XI.H.7. All programs must ensure the laundry room has an exterior mechanical ventilation system for the clothes dryer.

XI.H.8. All programs must have separate storage areas for:

a. Sanitary linen;
b. Food (Food supplies can not be stored on the floor.); and
c. Cleaning supplies.

XI.H.9. All programs must ensure an adequate heating and cooling system is provided to maintain temperature between sixty-eight (68) degrees and seventy-eight (78) degrees Fahrenheit.

XI.H.10. 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.

XI.H.11. All individuals admitted to Supervised Living or Residential Treatment Programs 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 Supervised Living or Residential Treatment 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.

XI.H.12 The provider must ensure that each individual served in a Supervised Living or Residential Treatment Program(s) has appropriate clean, comfortable, well-fitting clothes and shoes.

XI.H.13. The individuals living in the Supervised Living and Residential Living Programs must be registered as receiving services of the program.

XI.H.14. The program must provide 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. Staff must be able to respond to emergencies at a minimum within five (5) minutes.

XI.H.15. The program must have a full-time supervisor designated exclusively to the program.

XI.H.16. Supervised Living programs must, to the maximum extent possible, duplicate a "home-like" environment.

SECTION I- SUPERVISED LIVING OPTIONS

Supervised Living – Intellectual /Developmental Disabilities

XI.I.1. Supervised community living arrangements provide individually tailored supports which assist with the acquisition, retention, or improvement in skills related to living in the community. Learning and instruction are coupled with the elements of support,

supervisions 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.

XI.I.2. The expected outcomes for IDD Supervised Living include:

c. Individuals are provided the opportunity to live in the most integrated setting available according to their needed level of support.

d. Individuals are afforded choice of community integration activities.

XI.I.3. A maximum of six (6) individuals may reside in any single apartment or house.

XI.I.4. There must be at least one (1) staff person available for every six (6) individuals served. Additional staff may be required depending on each person's identified level of support.

XI.I.5. Supervised Living services for individuals with an intellectual/developmental disabilities can be provided in a group home or apartment setting and include;

b. Assisting individuals in monitoring their health and/or physical condition and maintaining documentation of the following in each person's record:

(1) Assistance with making doctor/dentist/optical appointments;
(2) Transporting and accompanying individuals to such appointments; and
(3) Conversations with the medical professional, if the individual gives consent.

b. 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 service plan.

XI.I.6. Each person entering Supervised Living services must participate in an individualized assessment, formal or informal, to be used to develop his/her service plan.

Therapeutic Group Homes – Children and Youth

XI.I.7. The primary mission of Therapeutic Group Homes (TGH) is to provide individualized services to youth with serious emotional disturbances in a structured, therapeutic home environment. Youth served in TGH's need intensive treatment in a community-based setting; however, they do not need services provided in a long-term psychiatric residential treatment center or in an inpatient (acute) hospital setting. Program emphasis in a TGH is on developing or increasing social and independent living skills youth need to make a successful transition to a less restrictive living situation.

TGH's typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.

XI.I.8. The expected outcomes for therapeutic group home services include:

a. Youth will develop independent living skills needed for transitioning to a more integrated living situation.

b. Youth will be diverted from placement in a long-term acute psychiatric or inpatient acute hospital setting.

XI.I.9. The maximum bed capacity of each TGH is ten (10) beds per home for youth twelve (12) years of age and over and eight (8) beds for youth under twelve (12) years of age. 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 youth served by the individual home.

XI.I.10. The TGH facility must be equipped with an operable electronic security system that has the capacity to monitor unauthorized entrance, egress, or movement through the facility.

XI.I.11. 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:

b. 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 every five (5) children or youth during all hours;

b. 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;

c. A full-time director (see requirement Standard VI.C.1) who is on-site at least forty (40) hours per week;

d. Other appropriate professional staff must be available to assist in emergencies, at least on an on-call basis, at all times; and

e. The Mississippi 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.

XI.I.12. A licensed psychiatrist and a professionally licensed or DMH credentialed mental health therapist with experience working with children/youth, on an employment or contractual basis, must be available for child/youth served by the TGH.

XI.I.13. 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.

XI.I.14. Children/youth in the TGH program must receive mental health therapy services sufficient to meet their needs, at least once per week or more frequently if needed. Documentation must be maintained in the case records of the children/youth indicating the progress/results of the mental health therapy services.

XI.I.15. Transition plans must be developed and included in the child/youth's record within ninety (90) days prior to completion of a TGH program.

Transitional Living Services – Substance Abuse and Rehabilitation

XI.I.16. The Transitional Living Substance Abuse Treatment Program provides a group living environment which promotes a life free from chemical dependency while encouraging the pursuit of vocational, employment or related opportunities. With group support, individuals acquire coping skills which enable them to become productive citizens in their communities.

XI.I.17. Expected outcomes for Transitional Living Services include:

d. All individuals participating in Transitional Living Services have completed a Primary Treatment Program within thirty (30) days.
e. An eighty-five percent (85%) utilization rate is expected.
f. Individuals are assisted with transitioning back to the community and maintaining a life free from chemical dependency.

XI.I.18. Staffing must be sufficient to meet service requirements. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Bureau of Alcohol and Drug Abuse for approval by the DMH Review Committee.

XI.I.19. An individual must have successfully completed a primary substance abuse treatment program before being eligible for admission into transitional residential

services. The primary substance abuse treatment program must be of a duration that consists of a minimum of thirty (30) days.

XI.I.20. The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling which accommodates individual employment schedules;

c. Family counseling;

d. 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;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational, educational, employment, or related activities.

XI.I.21. Transitional Living programs serving pregnant and parenting women/legal guardians with young children who reside on the program site must adhere to the following:

c. Adequate, secure, and supervised play space for the children of women served in the program must be provided.

d. 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.

Halfway House Services – Adult Mental Health

XI.I.22. Halfway House Services for individuals with serious mental illness must provide a readjustment and transitional living facility for individuals discharged from a psychiatric hospital who have demonstrated mental, physical, social and emotional competency to function more independently in the community. Halfway House Services may also be provided for individuals who need this service as an alternative to a more restrictive treatment setting.

XI.I.23. The expected outcomes for Halfway Half Services include:

a. Individuals are provided temporary housing for short term observation.
b. Individuals have decreased reliance on inpatient treatment.
c. Individuals are provided choices in access to employment, transportation, and community inclusion activities.

XI.I.24. Staffing must be sufficient to provide service requirements. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of MH Community Services for approval by the DMH Review Committee.

XI.I.25. The provider of the Halfway House program must have a written and implemented plan of service delivery which includes:

a. A schedule of activities or procedures providing access to the following:

(1) At least one hour of individual counseling or two hours of group counseling per week;
(2) At least four hours per week of skills training, e.g., daily living skills, social skills, assertiveness skills, etc;
(3) Family involvement;
(4) Proper medication usage training;
(5) Educational services;
(6) Proper nutrition habits training;
(7) Recreation and social activities;
(8) Prevocational and/or vocational training; and
(9) Orientation to community resources.

XI.I.26. The duration of each resident's stay must not exceed six (6) months without prior written approval. Requests should be directed to the Director, Bureau of Community Services for approval by the DMH Review Committee.

Group Home Services – Adult Mental Health

XI.I.27. Group Home Services for adults with serious mental illness provide residential accommodations in a home-like environment, with supervision and training for adults with a serious mental illness (as defined by the Mississippi DMH).

XI.I.28. The expected outcomes for Group Home Services include:

a. Individuals are be prepared to move to more individual/permanent housing options.
b. Individuals have decreased reliance on inpatient treatment.

XI.I.29. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of MH Community Services for approval by the DMH Review Committee.

SECTION J- RESIDENTIAL TREATMENT OPTIONS

XI.J.1. All Residential Treatment facilities (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.

XI.J.2. The Residential Treatment facility (all types) must be equipped with an operable electronic security system that has the capacity to monitor unauthorized entrance, egress, or movement through the facility.

XI.J.3. The Residential Treatment facility (all types) must have emergency exit doors operated by a magnetic/electronic (or similar) release system. This system must be in a readily accessible and in a secured location that is accessible only by staff.

XI.J.4. The Residential Treatment Program (CDU) must meet the licensure and certification requirements of the appropriate responsible agency, as required by state law.

Crisis Residential Treatment Services – Children and Youth

XI.J.5. Crisis Residential Treatment Services (excludes inpatient and psychiatric residential treatment facilities licensed and certified by the Mississippi State Department of Health) provide brief assessment with immediate and intensive residential treatment services, typically followed by intensive outreach/aftercare treatment. Providers that make available a residential treatment component as part of a comprehensive emergency/crisis response program must meet the standards in this section. Additionally, providers of Crisis Residential Treatment Services for C/Y must also meet the standards in Parts VIII, Sections A and B.

XI.J.6. The expected outcomes for Crisis Residential Treatment Services for C/Y include:

c. Children/youth experiencing a crisis obtains the support needed in order to diffuse the crisis in a manner that will maintain the child/youth in a community residential setting.
d. Children/youth have a decreased reliance on inpatient treatment.

XI.J.7. To ensure that the staff on-site is of a sufficient number to provide adequate supervision of child/youth in a safe, therapeutic environment at least one (1) staff for every four (4) child/youth must be assigned to direct service responsibilities during all

hours. At least one (1) staff on duty must be a professional staff member with at least a Bachelor's degree in a mental health or related field.

XI.J.8. The provider must ensure that an adequate number of professional staff are available and on-site and are qualified by training and experience to provide programmatic direction and supervision. The staffing composition pattern will be subject to approval by the DMH Director, Bureau of Community Services, 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 individual homes. The staffing composition of all Crisis Residential Treatment programs must include, at a minimum, the following:

a. A full-time director who is on-site, at least forty (40) hours per week, and who meets the minimum qualifications as stated in Standard VI.C.1(a);

b. Availability of a licensed psychiatrist with experience working with children/youth, on an employment or contractual basis;

c. A full-time mental health therapist who is on-site, at least forty (40) hours per week, and who meets the minimum qualifications as stated in Standard VI.C.1(h).

d. Availability of an additional mental health professional staff person, with at least a Bachelor's degree in a mental health or related field, if needed to meet staffing requirements.

XI.J.9. Children/youth served by the Crisis Residential Treatment program must meet the following eligibility criteria:

a. Under the age of nineteen (19) years and within a developmentally appropriate age range to benefit from the services of the program as specified/determined by the program;

b. Designated staff confirm that the individual is experiencing severe, demonstrable emotional crisis(es) that can be appropriately addressed through the specific services provided by the program; and

c. The condition/situation indicates that Crisis Residential Treatment could divert them from inpatient care or other more restrictive placement.

XI.J.10. Crisis Residential Treatment programs must provide the following services:

a. Medical and psychological evaluation and assessment by appropriately certified individuals of the need for referral to other specialized treatment programs or services (such as alcohol/drug treatment);

b. Psychiatric consultation;

c. Case Management;

d. Family education and counseling; and

e. Access to intensive crisis intervention aftercare.

XI.J.11. Children/youth served by the Crisis Residential Treatment program must, at a minimum, receive an initial individual therapy session within the first four (4) days of admission.

XI.J.12. Team meetings of designated treatment and other staff, as needed by individual child/youth, must be held every three (3) days during the child/youth's stay to assess progress toward objectives on the Individualized Individual Service Plan and to make any revisions necessary to continue effective treatment. Attempts must be made and documented as part of Individual Service Plan development/revision to include the presence and/or input of parent(s)/legal guardian(s) and child/youth (as developmentally appropriate) at team meetings.

XI.J.13. The child's/youth's stay in the Crisis Residential Treatment Program must not extend beyond a maximum of twenty-one (21) consecutive days. An extension of this timeframe should be submitted in writing to the Director, Bureau of Community Services for approval by the DMH Review Committee.

XI.J.14. If a child/youth is readmitted to the Crisis Residential Treatment Program at any time after a previous discharge from the program, they must be evaluated for and again meet eligibility criteria specified in Standard XI.J.9.

Chemical Dependency Unit Services – Substance Abuse Prevention and Rehabilitation

XI.J.15. Chemical Dependency Unit Services include inpatient or hospital-based services for individuals with more severe alcohol and/or drug abuse problems and who require a medically-based environment. Treatment usually includes detoxification, group, individual, and family therapy, education services explaining alcohol/drug dependency, personal growth, and the recovery process, aftercare, and family counseling.

XI.J.16. The expected outcome for Chemical Dependency Unit Services is for all individuals in CDU Services to receive all needed components of the service.

XI.J.17. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of Alcohol and Drug Abuse for approval by the DMH Review Committee.

XI.J.18. Programs serving children or youth must also comply with the following Operational Standards Part XI, Section C and Standards XI.I.7 through XI.I.15.

XI.J.19. The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling with each individual;

c. Family counseling;

d. At least ten (10) hours per week of education services dealing with substance abuse and addiction, self-help/personal growth, social skills, anger management, and recovery process, and a philosophy of living which will support recovery;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational counseling and planning/referral for follow-up vocational services.

g. For children and youth, the academic schedule indicating school hours.

Primary Residential Services – Substance Abuse Prevention and Rehabilitation

XI.J.20. The Primary Residential Substance Abuse Treatment Program is an intensive residential program for individuals who are addicted to or abuse alcohol/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. Because alcohol and drug dependency is 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.

XI.J.21. The expected outcomes for Primary Residential Services include:

c. Individuals entering Primary Residential Services will complete the program within thirty (30) days and maintain a dependency free lifestyle.

d. An eighty-five percent (85%) utilization rate is expected.

XI.J.22. Programs serving children or youth must also comply with the following Operational Standards Part XI, Section C and Standards XI.I.7 through XI.I.15.

XI.J.23. Primary Residential Treatment programs serving pregnant and parenting women/legal guardians with young children who reside on the program site must also provide for adequate, secure, and supervised play space for the children of women served in the program.

XI.J.24. Programs must have accessibility either through program staff or affiliation agreement/contract to the following:

a. A licensed psychiatrist with experience in the treatment of substance abuse/addiction; or,

b. A licensed psychologist with experience in the treatment of substance abuse/addiction; and

c. A licensed physician with experience in the treatment of substance abuse/addiction.

XI.J.25. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week. Minimum level of staff for each shift must be submitted to the Director, Bureau of Alcohol and Drug Abuse for approval by the DMH Review Committee.

XI.J.26. The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling with each individual;

c. Family counseling;

d. 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;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational counseling and planning/referral for follow-up vocational services.

g. For child/youth, the academic schedule indicating school hours.

XI.J.27. Primary Residential programs serving pregnant and parenting women/legal guardians with young children who reside on the program site must adhere to the following:

d. Adequate, secure, and supervised play space for the children of women served in the program must be provided.

e. 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.

Crisis Stabilization Units (CSU) – Adult Mental Health

XI.J.28. CSU services are time-limited residential treatment service designed to serve adults with severe mental health episodes that if not addressed would likely result in the need for inpatient care. The community-based service setting provides intensive mental health assessment and treatment. Follow-up outreach and aftercare services are provided as an adjunct to this service.

XI.J.29. The expected outcomes for Crisis Stabilization Units include:

d. Individuals will be diverted from further treatment at a state psychiatric facility.

e. Individuals will remain in their community settings in order to receive services and supports in order to stabilize their symptoms of mental illness.

f. Decrease number of admissions to state psychiatric facilities.

XI.J.30. The program must maintain one staff member to each four (4) or fewer residents twenty-four (24) hours a day, seven (7) days a week. Each program must post in an area accessible to the public a staffing pattern approved by the DMH (signed by the Director, Bureau of Community Services) to include qualifications for each position and the

number of positions per shift for each day of the week. Nursing services must be provided during all shifts.

XI.J.31. All providers of CSU services must develop policies and procedures which, at a minimum, address the following:

a. Twenty-four-hour-a-day, seven-days-a-week basis emergency admissions;

b. Safety and well-being of individuals who are experiencing a crisis, including procedures for the following:

(1) Notification of the program's attending physician;
(2) Implementation of programs and staff training for addressing potentially dangerous behaviors (such as aggression, suicide, etc.); and
(3) Observation of individual experiencing a crisis;

XI.J.32. Each program must have the following services available as needed by the resident;

a. Evaluation;
b. Observation;
c. Crisis counseling;
d. Alcohol and drug counseling;
e. Case management; and
f. Therapeutic activities, including recreational, educational, and social/interpersonal, the intent of which is to involve the individual in reality-oriented events, must be available at least three (3) hours per day. Participation should be documented in the individual's record.

XI.J.33. Individuals must be involved, to the greatest extent possible, in the operation and decision-making process of the program.

a. Individuals must be involved, at incremental levels depending on capability, in the operation of the program. This involvement may include such things as formulation and monitoring of CSU rules, as well as the daily operation of the program, e.g., cooking, cleaning, menu planning, activity planning, etc.;

b. Individuals must have meaningful involvement in the evaluation of the program, which must include, at a minimum and as appropriate, family and consumer satisfaction surveys.

XI.J.34. The DMH only allows seclusion to be used in a CSU.

XI.J.35. If a program uses a room for seclusion(s), the program must obtain written approval of the use of such room from the Director, Bureau of Community Services prior to its use for seclusion. To be approved for use for seclusion by the DMH, a room must meet the following minimum specifications:

a. Be constructed and located to allow visual and auditory supervision of the individual;

b. The dimensions of the room must be at least forty-eight (48) square feet; and

f. Be suicide resistant and have break resistant glass (if any is utilized in the room or door to the room).

XI.J.36. 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:

a. Clear definition(s) of seclusion and the appropriate conditions and documentation associated with its use. Seclusion is defined as behavioral control technique involving locked isolation. Such term does not include a time-out.

b. Requirements 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;

c. Requirements 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;

d. Requirements 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, and that such orders must be documented in the case record. The following requirements must be addressed in the policies and procedures regarding the use of seclusion and implementation (as applicable) documented in the individual case record:

(1) Orders for the use of seclusion must never be written as a standing order or on an as needed basis (that is, PRN);

(2) The treating physician must be consulted as soon as possible, if the seclusion is not ordered by the individual's treating physician;

(3) A physician or other licensed independent practitioner must see and evaluate the need for seclusion within one hour after the initiation of seclusion;

(4) 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;

(5) Seclusion must be in accordance with a written modification to the Individual Service Plan of the individual being served;

(6) Seclusion must be implemented in the least restrictive manner possible;

(7) Seclusion must be in accordance with safe, appropriate techniques; and,

(8) Seclusion must be ended at the earliest possible time.

e. Requirements that seclusion is not used as a form of punishment, coercion, or staff convenience;

f. Requirements that all staff who have direct contact with individuals being served must have ongoing education and training in the proper, safe use of seclusion;

g. 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; and,

i. Requirements that the original authorization order of the seclusion may only be renewed for up to a total of twenty-four (24) hours (in accordance with the limits of these standards) by a licensed physician or licensed independent practitioner, if less restrictive measures have failed.

XI.J.37. In addition to the following two standards regarding use of seclusion, providers of CSU must also meet all standards in Part V, Section A.

XI.J.38. Standard V.A.2(c) 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 maintained of the assessment in the individual's record.

PART XII

OUTPATIENT SERVICES

SECTION A- OUTPATIENT MENTAL HEALTH SERVICES

XII.A.1. Outpatient mental health services include intake bio-psycho-social assessment, and individual, group, and multi-family group therapies (excluding day treatment and case management) are the least intensive and most typically used interventions in the mental health field.

XII.A.2. The expected outcomes of outpatient mental health services include:

c. Individuals will achieve their individualized goals and objects identified on Individual Service Plans.
d. Individuals will experience a reduction in negative symptoms.

XII.A.3. Intake bio-psycho-social assessment is 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. The intake bio-psycho-social assessment must be completed by a mental health and/or intellectual/developmental disabilities therapist.

XII.A.4. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and an individual receiving services.

XII.A.5. Family Therapy is defined as 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.

XII.A.6. Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2) but no more than eight (8) 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.

XII.A.7. Multi-Family Group Therapy is defined as psychotherapy that takes place between a mental health therapist and family members of at least two 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.

XII.A.8. The provider must have a written plan for services that identifies the manner in which each of the following special target populations will be served:

a. Elderly persons;

b. Individuals with serious mental illness;

c. Individuals with a dual diagnosis of mental illness and substance abuse;

d. Individuals with a dual diagnosis of mental retardation and mental illness;

e. Persons discharged from inpatient care;

f. Individuals with mental illness who are homeless.

XII.A.9. Outpatient services must be available and accessible at appropriate times and places to meet the needs of the population to be served. The program must establish a

regular schedule, with a minimum of three (3) hours weekly for the provision of outpatient services during evenings and/or weekends.

XII.A.10. For DMH/C providers of Outpatient Therapy Services for Children/Youth

At a minimum, one outpatient therapist must be available at a school site in each public school district in the region served by the Community Mental Health Center (DMH/C).

XII.A.11. For DMH/C providers of Outpatient Therapy Services for Children/Youth

If the school district does not accept the provider's offer to provide outpatient therapy services, written documentation of nonacceptance (for the current school year) by the school district superintendent must be on file at the community mental health center for review by DMH personnel.

XII.A.12. For DMH/C providers of Outpatient Therapy Services for Children/Youth

The provider of outpatient services must have a written plan for services that identifies the manner in which each of the following special target populations of children/youth will be served:

a. Children/youth with a serious emotionally disturbance;

b. Children/youth with a dual diagnosis of serious emotional disturbance and substance abuse;

c. Children/youth with a dual diagnosis of serious emotional disturbance and mental retardation;

d. Children/youth transitioning from residential care (this includes psychiatric inpatient care, psychiatric residential treatment facilities, therapeutic group homes and therapeutic foster care).

e. Children/youth with serious emotional disturbance who are homeless;

f. Youth with serious emotional disturbance in transition from the children/youth services system to the adult service population.

XII.A.13. There must be written policies and procedures for:

a. Admission;

b. Coordination with case management and/or other services in which the individual is enrolled;

c. Follow-up designed to minimize dropouts and maximize treatment compliance;

d. Therapist assignments;

e. Referral to other appropriate services as needed; and

f. Discharge planning.

XII.A.14. The provider must have implemented policies and procedures that ensure that, at a minimum, for youth being discharged from inpatient care, residential treatment centers and therapeutic group homes:

a. The youth (and family member(s) as appropriate) are given an appointment with a mental health professional within two (2) weeks after referral;

b. The youth (and family member(s) as appropriate) are given an appointment with a physician within four (4) weeks after referral;

c. The youth (and family member(s) as appropriate) are evaluated for and/or enrolled in case management services within two (2) weeks after referral for community services;

d. Inpatient referral facilities have current contact office and phone number information so that aftercare appointments are made within the above required time frames; and,

e. Professional staff have been trained and are knowledgeable in the policies and procedures in a.-d. above.

XII.A.16. The program must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that:

a. Provide a phone number where contact can be made to arrange for an appointment;

b. Assure that only one call by the requesting person is needed to receive an appointment.

SECTION B- OUTPATIENT SUBSTANCE ABUSE AND REHABILITATION SERVICES

General Outpatient Substance Abuse and Rehabilitation Treatment Services

XII.B.1. General outpatient substance abuse treatment is appropriate for individuals in need of substance abuse services whose clinical condition or environment circumstances do not require a more intensive level of care. Providers of outpatient substance abuse treatment must provide the following services:

a. Individual therapy/counseling;

b. Group therapy/counseling; and

d. Family therapy/counseling.

XII.B.2. The expected outcome for General Outpatient Substance Abuse and Rehabilitation Services is for individuals to receive individual, group and/or family counseling to assist them in maintaining recovery and decrease need for more restrictive services.

Intensive Outpatient Program (IOP)

XII.B.3. The 10-Week Intensive Outpatient Program (IOP) is a community-based outpatient program which provides an alternative to traditional residential treatment or hospital settings. The program is directed to persons who need services more intensive than traditional outpatient services, but who have less severe alcohol and drug problems than those typically addressed in residential treatment. The IOP allows individuals to continue to fulfill his/her obligations to family, job, and community while obtaining intensive treatment.

XII.B.4. Expected outcome for the Intensive Outpatient Program is to allow individuals to receive intensive 10-12 weeks of treatment in their communities rather than in a restrictive residential or hospital setting.

XII.B.5. Intensive Outpatient Programs must provide the following services:

a. Group lecture or therapy for a minimum of three (3) nights a week for three (3) hours each night for at least ten (10) weeks;

b. Individual therapy at a minimum of one (1) counseling session, for a minimum of one hour, per week;

c. Involvement of family or significant others as necessary to meet needs of the individual.

PART XVII

INTELLECTUAL/DEVELOPMENTAL DISABILITIES SERVICES

All sections contained in this part pertain specifically to services and supports that are available to individuals with intellectual/developmental disabilities.

SECTION ~~B~~ A- EARLY INTERVENTION SERVICES

~~Early Intervention Services for children under five years of age with mental retardation/ developmental disabilities provide opportunities which promote the developmental growth of children in cognitive, physical, social/emotional, communication, and adaptive functioning areas. Early Intervention Services also assist families by providing parents information, materials, and support.~~

XVII.A.1. 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.

XVII.A.2. The expected outcomes for Early Intervention Services include:

c. Children will experience a reduction in risk factors associated with developmental delays.
d. Families are linked to community resources.

XVII.A.3. All Early Intervention Programs and Child Development Programs must adhere to the following standards:

~~600.0~~ a. 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 ~~their~~ available services.

~~600.1~~ b. The program must conduct and provide documentation of annual child find in the community to assist in the early identification of children with developmental disabilities or children who are at risk of developing developmental disabilities. ~~Programs must submit an annual report of child find efforts as part of their Final Narrative.~~

~~600.2 Each child under three years of age must be referred to the First Steps Early Intervention Program (FSEIP) within two working days of identification unless referred from FSEIP. Documentation of the referral must be maintained and include the date of the initial contact with the family and the date of the subsequent referral to the appropriate FSEIP service coordinator.~~

c. Families of children under three years of age must be informed of the First Steps Early Intervention Program (FSEIP) unless referred from FSEIP.

~~600.3 Each child under five years of age must receive a comprehensive, nondiscriminatory, multidisciplinary evaluation by qualified personnel within 45 days of referral to the program and at least every three years thereafter. The evaluation must include, at a minimum, a review of pertinent records related to the child's current health status and medical history while evaluating the following developmental areas:~~

~~a. Cognitive;~~

~~b. Physical, including vision and hearing;~~

~~c. Communication;~~

~~d. Adaptive; and~~

~~e. Social/emotional.~~

~~600.4* Upon admission and annually thereafter, a family assessment must be conducted and maintained in the child's record. The assessment must include, but not be limited to, identifying resources, priorities, and concerns of the family relating to enhancing the development of the child.~~

~~600.5~~ d. Within 30 days of admission, a dated photograph of the child must be placed in his/her record and be updated annually for children birth to three years and every three years for children four to six years.

e. Program staff must participate in review, revisions, and annual updates of each child's Individual Family Service Plan (ISFP).

~~600.6* Early Intervention Programs must provide activities which promote the cognitive, physical, emotional/social, communication, and adaptive development of children.~~

~~600.7 The program must provide or access services as needed and 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.~~

~~600.8* When OT, PT and/or SLP services are provided by a specialist (program staff, consultants, and private providers), specific information and documentation must be placed in the child's record including, at a minimum,~~

~~a. Basic information on the OT, PT, and/or SLP goals to be implemented by the specialist;~~

~~b. Any special techniques needed for the safe handling of a child;~~

~~c. How program staff might implement any recommended special procedures/techniques into the child's educational program; and~~

d. Training provided by the specialist(s) for program staff.

When information is unavailable, documentation must be maintained in the child's record of attempts to contact the specialist.

600.9 The program's qualified teacher must conduct within 30 days of admission and annually thereafter, an annual 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 habilitation plan.

601.0 The program must establish and maintain a data collection system for monitoring a child's acquisition of skills and maintenance of progress toward habilitation objectives. Data must be collected at least weekly. Programs which provide daily services to children must document and demonstrate how objectives are being addressed daily if data is only collected one time per week.

601.1 The setting for early intervention services must be conducive to maturation and learning and include:

a. Equipment that is of an appropriate size and nature to be functional for the child using it;

b. Accessibility to materials, toys, and equipment to stimulate, motivate, and entice children to explore the world around them; and

c. The procurement of special adaptive equipment for children with severe physical disabilities, when required.

601.2 When invited by the FSEIP Service Coordinator, staff must participate in the development of each child's Individual Family Service Plan (IFSP), necessary reviews and revisions, and the annual updates. If unable to attend, documentation of staff's involvement through other means must be maintained (conference call, making pertinent records available, etc.).

601.3 With written parental consent, a child's progress on his/her habilitation plan goals and objectives must be submitted to the appropriate FSEIP service coordinator, upon their request, for use in IFSP reviews, within five working days of receiving the request.

~~601.4 Children should be served in natural environments when possible and according to parental wishes. Natural environments are any settings in the community where the child would be if he or she did not have a disability. For children served in locations other than the natural environment, documentation must be maintained on the contact summary in the child's record that this is parental choice.~~

~~601.5 The program must determine the extent to which each child has interaction with the same age peers and document how they will assist the family in providing opportunities for this type of interaction, if not currently available.~~

~~601.6~~ f. The program must have goals and objectives for at least quarterly parental involvement and education that is based on the expressed interests/needs of the parents as ascertained from a parental interest/needs survey. ~~The survey must be conducted at least annually and the results analyzed in a written report. Parent programs/activities provided must be directly related to the results of this survey.~~

g. 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.

h. 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.

(3) Participate in IFSP meetings to discuss transition activities as requested through written prior notice form from First Steps.

~~601.7* The program must provide information to parents about developmental disabilities, developmental patterns, and other information pertinent to their child that is understandable to the parents. Documentation that this information has been provided must be maintained in each individual child's record. Information provided to parents must include at least the following:~~

a. Providing parents with activities that assist in implementing objectives from the habilitation plan in the child's daily activities both at home and in other settings, to enhance the family's capacity to meet the developmental requirements of their child;

b. Providing and/or assisting with acquisition of specialized instructional material and/or adaptive equipment, as may be required by the child;

c. Assisting the family in adapting home equipment, as may be required by the child;

d. Training of family by appropriate staff (e.g., PT, OT, SLP, etc.) about the use of specialized instructional material, adaptive equipment, and positioning and handling techniques, as may be required by the child, that enhance the family's capacity to meet the developmental challenges of their child;

e. Providing information on available resources for obtaining additional services and specialized equipment, as may be required by the child;

f. Coordinating the child's program with services delivered by others (i.e., First Steps, Head Start, day care, private therapists, Community Mental Health Centers, etc.); and

g. Providing information to families that enables them to become better advocates for their children.

601.8* For programs serving children birth to three years of age, there must be written documentation at each program site of quarterly collaborative efforts with FSEIP staff which includes, but is not limited to:

a. Public awareness and education activities;

b. Training on Part C regulations and current Early Intervention practices;

c. Joint IFSP and Habilitation Plan meetings;

d. Child find activities.

~~601.9* Documentation of transition objectives must be in the child's record at least six months prior to the child's third birthday and must include at least the following:~~

~~a. Discussions with and information for parents regarding future services/supports and other matters related to the child's transition (by 30 months of age);~~

~~b. Procedures to prepare the child for changes in service delivery, including steps to help the child adjust to and function in a new setting such as the provision of group instruction and activities or referral to other programs that could offer opportunities to interact with other children like Head Start or child care centers (by 30 months of age);~~

~~c. With parental consent, the transmission of information about the child to the local education agency (LEA) to ensure continuity of services, including evaluation and assessment information and copies of IFSP's and habilitation plans that have been developed and implemented (by 30 months of age); and~~

~~d. Participation in a meeting to discuss transition options with the FSEIP Service Coordinator, LEA/Head Start, program staff, and parents (by 33 months of age).~~

~~602.0 For programs providing group activities for children with transition objectives, documentation of habilitation plan objectives addressed during group instruction must be maintained in the Progress Notes.~~

~~602.1 Each 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.~~

XVII.A.4. First Steps Early Intervention Programs (FSEIP) must adhere to the following.

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 primary service provider (specified on page 6 of IFSP) must complete outcomes rating for child within sixty (60) days prior to exit of the program. If the program is a service provider (other than primary), updated assessment and other information must be given to the primary service provider with in sixty (60) days prior to exit of the program.

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.

XVII.A.5. Child Development Services must adhere to the following:

a. Within thirty (30) days of admission and at least annually thereafter, 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. The program must 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. When OT, PT and/or SLP services are provided, the following must be documented and maintained in the child's record:

(1) Training provided by the specialist(s) for program staff.

(2) Any special techniques needed for the safe handling of a child; and

(3) How program staff might implement any recommended special procedures/techniques into the child's educational program.

d. The program must document progress toward meeting goals and objectives as required in the DMH Record Guide.

e. 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.

f. 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.

SECTION ~~C~~ D- WORK ACTIVITY SERVICES

~~Work Activity Services for persons 16 years and older with mental retardation/ developmental disabilities provide opportunities for the acquisition of necessary work and living skills. Services provided in the work activity environment are directed towards increasing productivity, self-sufficiency, and community integration.~~

XVII.D.1. 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.)

XVII.D.2. The expected outcomes for Work Activity Center Services include:

a. Individuals increase their productivity.
b. Individuals increase their self-sufficiency.
c. Individuals increase their community inclusion activities.

XVII.D.3. ~~700.0*~~ Each program must be certified by the U.S. Department of Labor and possess the appropriate Department of Labor certificate and have it posted in a public area at each work activity center site.

XVII.D.4. ~~700.1*~~ Work activity services must ~~provide at least the following as needed and wanted by the individual:~~ include:

a. Work which is:

(1) ~~Work must be~~ real, remunerative, productive, and satisfying for the individual served ~~for both transitional and extended work periods;~~

(2) ~~Work must be both~~ planned and adequate to keep all individuals productively and appropriately occupied;

~~(3) Each individual's habilitation plan must contain goals and objectives for the acquisition of skills for specific work tasks and must be taught in either the workshop or on the job; and~~

b. Non-work <u>which:</u>

<u>(3) Is intended to increase and enhance activities which allow the individual to be more self sufficient and to increase community integration;</u>

<u>(4) Takes place when work is reduced and/or when the individual chooses.</u>

~~Each individual's habilitation plan must identify optional work and/or community integration or community employment activities, based on personal choice, to be addressed when available work is reduced or when the individual chooses. Activities may include, but are not limited to, the activities indicated below:~~

~~(1) Community employment related activities such as:~~

~~(a) interviewing skills;~~

~~(b) visiting community job sites (job exploration);~~

~~(c) transportation training;~~

~~(d) relationships/communication at work; and/or~~

~~(e) providing information about employment services.~~

~~(2) Application to or utilization of community resources (community awareness) such as:~~

~~(a) banks;~~

~~(b) transportation;~~

~~(c) recreational/leisure activities/places;~~

~~(d) community living options; and/or~~

~~(e) medical services.~~

~~(3) Daily living skills activities such as:~~

~~(a) shopping at the grocery store/supermarket;~~

~~(b) using the pay telephone;~~

~~(c) preparing meals;~~

~~(d) grooming and appearance;~~

~~(e) making doctors appointments;~~

~~(f) toileting skills; and/or~~

~~(g) eating skills.~~

XVII.D.5. The program must have adequate work to keep individuals productively occupied while at the work activity center.

a. If there is not adequate work to allow everyone to be productively occupied, the program must have documentation of how it is actively seeking a variety of work.

b. Programs found not to have adequate work will be placed on probation for a maximum of six (6) months.

(1) Programs on probation must submit monthly reports to BIDD (on required forms) detailing their activities and progress towards locating and obtaining adequate work.
(2) Programs which do not have sufficient documentation of how they have tried to locate and obtain adequate work may be decertified.
(3) Programs which have sufficient documentation of how they have tried to locate and obtain adequate work, yet have not been able to secure such work, may continue to operate at the discretion of the Director, BIDD.

XVII.D.14. ~~700.2*~~ A minimum of 50 square feet of 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.

~~700.3 The program must have adequate floor space for a lounge/break/dining area separate from the work area.~~

XVII.D.15. ~~700.4γ~~ Preventive measures must be utilized at all times to provide for the safety of the individuals and staff which include, at a minimum:

~~a. Safety in operating machinery;~~

~~b. Protective clothing, shoes, and eyewear;~~

~~c. Proper storage of flammable liquids or other harmful materials in containers, if not the original, being clearly marked to identify contents;~~

~~d. Replacement of worn or frail electrical cords or machinery;~~

~~e. Maintaining the shop and equipment in a safe manner;~~

~~f. Performing required maintenance of equipment; and~~

~~g. Periodic training on safety and providing instruction on the use of equipment.~~

d. The safe use of equipment;

e. The use of protective clothing, shoes, and eyewear;

f. 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;

d. The storage and control of raw materials and finished products outside the work area;

h. The replacement of worn or frail electrical cords or machinery; and

i. The maintenance of the site and equipment in a safe manner.

~~700.5 Records pertaining to individual wages must include, at a minimum, the following:~~

~~a. Individual's name;~~

~~b. Hours worked;~~

~~c. Task(s) performed;~~

~~d. Wages paid;~~

~~e. Method of payment (cash or check); and~~

~~f. Individual's signature, upon payment.~~

XVII.D.11. ~~700.6~~ Community wage rate information must be obtained annually and shall include at a minimum the following:

a. Prevailing wage for the type or similar type of work being performed;

b. Dates that community wage rate information was obtained; and

~~j.~~ Source of information~~.~~

XVII.D.7. Wage payments must be monetary and not in-kind or barter. Records pertaining to individual wages must include, at a minimum, the following:

a. Individual's name;

b. Hours worked;

c. Task(s) performed;

d. Wages paid; and

e. Method of payment (cash, check, direct deposit.)

XVII.D.8. Each person must receive a written statement for each pay period which must include:

a. Gross pay;

b. Net pay;

c. Hours worked;

k. Deductions; and

e. The individual's signature indicating he/she received a written statement. These signatures must be maintained in the individual's record.

XVII.D.9. ~~700.7~~ Pay periods for individuals will not exceed 31 calendar days.

~~700.8 Each person must receive a written statement for each pay period indicating gross pay, hours worked, deductions, and net pay.~~

~~700.9 Wage payments must be based on a system of individual performance rather than pooled and/or group wage payments. Documentation of properly completed time studies must be maintained and be available for review by DMH staff.~~

~~701.0 Wage payments must be monetary and not in-kind or barter.~~

~~701.1 Accounting records must be maintained on generated income from work contracts that detail dollar amounts and fund utilization as specified in Standard 30.2 d.~~

~~701.2 The program must maintain evidence of prior written authorization from the Department of Mental Health/Bureau of Mental Retardation 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:~~

~~a. Enhancing or enriching the program; and~~

~~b. Not being used as part of the required match.~~

~~701.3* The work activity center must assess and document each person's desire for community employment placement at least annually and make referrals to Employment Services when desired.~~

XVII.D.6. ~~701.4*~~ The program, to assure reasonable accommodation in assisting the individual in increasing his/her productivity, must, as needed:

a. Modify equipment, jigs, and fixtures;

b. Modify the work site and commonly used surrounding areas;

c. Purchase aids and devices to assist individuals; and/or

d. Allow flex time, part-time, or extended break time.

~~701.5 The program must prepare a handbook to be distributed to all persons served and document annual reviews conducted either individually or in a group setting which outline:~~

~~a. The benefits and responsibilities of the organization and the person served;~~

~~b. Hours of operation;~~

~~c. Vacation days;~~

~~d. Closures of the program;~~

~~e. Fringe benefits;~~

~~f. Nondiscrimination provisions;~~

~~g. Grievance and appeal procedures for those served or their parents, guardians, or personal representatives which must specify:~~

~~(1) Levels of review;~~

~~(2) Time frames for decision making;~~

~~(3) Written notification procedures; and~~

~~(4) The rights and responsibilities of each party.~~

~~h. An explanation of the means used by the program to preserve human rights and the mechanism by which the person has access to that system; and~~

~~i. Employment opportunities.~~

XVII.D.13. ~~701.6 Meetings between individuals served and management must be held and documented~~ Work Activity Programs must meet at least annually to discuss matters of mutual concern ~~which, at a minimum, should:~~ The program must maintain minutes for the meeting and ensure at least the following are addressed:

a. Individuals are informed ~~those served~~ of any aspects of program operations and plans which concern their wages or welfare;

b. ~~Enlist informed cooperation to achieve efficient use of program resources in the best interest of those served; and/or~~

~~c. Seek suggestions from those served and answer their questions.~~

b. Individuals are asked for suggestions for changes/improvements they would like to see; and

c. Individuals are afforded the opportunity to ask questions and receive answers.

~~701.7 Persons placed on a job in a competitive work setting, if terminated from that job, shall be guaranteed a position in the work activity program as soon as an opening is available.~~

~~701.8* The program must document how they aggressively seek and provide a variety of work, which represents job opportunities in the community, to fulfill the training needs of the persons served.~~

~~701.9 Provision must be made for storage and control of raw materials and finished products outside the work area.~~

XVII.D.12. The program must have a "Return to Work Activity policy" which ensures individuals who leave the program to work in the community can return to the work activity center if their community job ends.

~~SECTION D - CASE MANAGEMENT SERVICES~~

~~Case Management Services assist persons with mental retardation/developmental disabilities in gaining access to needed social, medical, and educational services. Service components include: outreach, intake and needs assessment, emergency/crisis intervention, information and referral, service planning, service coordination, and follow-along.~~

~~800.0* Case management must be a voluntary service. Individuals and/or their guardians must annually sign a Case Management Services Agreement during a face to face meeting which indicates their desire for~~

services. At any time, an individual may request, in writing, the termination of case management services.

800.1* The case management program must make available and must include, at a minimum, service components to assist individuals in securing resources needed and chosen by the individual and/or family which will help the individual live successfully in the community. These services must include, but not be limited to the following:

a. Outreach Services - Case managers must develop a thorough knowledge of service agencies (e.g., community living services, day programs, residential facilities, etc.) in their region and throughout the state. This must include visiting placement sites, establishing contact persons in the agencies, and being familiar with application procedures, waiting lists, etc. so that referral sources are aware of case management services.

b. Intake Services - Case managers must obtain complete identification data on all individuals including medications used, contact with other agencies, addresses, phone numbers, family, etc.

c. Emergency/Crisis Intervention - Case managers must be aware of resources and procedures for emergency placement or intervention when an individual is in need of immediate attention, such as respite services at the state residential centers and/or hospital admission.

d. Information and Referral - Case managers will provide individuals, families, and other service agencies with information regarding placement sites, financial resources, application procedures, etc. The case manager must have knowledge of or be able to obtain information about the referral process to other programs and services.

e. Diagnosis and Evaluation - While the case manager does not perform evaluations or diagnose individuals, he/she will be responsible for referring an individual for evaluation, if needed, or obtaining copies of prior evaluations, if one has been performed within the established time line before the individual is enrolled in the case management system.

f. Service Planning - The individual, family/guardian, and case manager must jointly develop a service plan according to the desires and preferences of the individual. The development of the

plan must occur during a face to face meeting that is conducted at least annually. This plan is subject to change in accordance with the individual's desire for services and supports.

g. Service Coordination - The case manager will assist an individual to access all the services and supports he/she desires by making the referral or assisting the individual in contacting the service/support. The case manager will also assist the individual in making the transition to the new service/support. The case manager will stay in contact with the individual and service agencies once an individual has been referred for services and support to ensure that the individual has begun and continues to receive the services/supports he/she desires.

800.2* The case management program must at a minimum:

a. Establish a case management unit with a full-time case management supervisor;

b. Assign one single, full-time case manager to individuals enrolled in case management services;

c. Assign caseloads to case managers utilizing the following ratios:

(1) Primary Status- maximum of 40 individuals;

(2) Follow-Along Status- maximum of 60 individuals;

(3) Combination of Primary and Follow-Along Status- maximum of 50 total individuals with 20 Primary Status individuals and 30 Follow-Along Status individuals; or

(4) Combination of Follow-Along and Tracking Status- maximum of 80 individuals.

(5) Combination of Primary, Follow-Along, and Tracking Status-maximum of 60 total individuals with 20 Primary status individuals, 20 Follow-Along status individuals, and 20 Tracking Status individuals; and

(6) Potential/Temporary Status-Case Managers serving individuals in Potential/Temporary Status cannot exceed the ratios as stated above.

d. Maintain a list of each case manager's case load that must be available for review by DMH staff.

800.3* The case management program must have a current comprehensive file of community resources which includes, but is not limited to:

a. Name of agency;

b. Eligibility requirements;

c. Contact person;

d. Services available; and

e. Telephone number.

800.4* The case management program must have documentation that they have developed relationships with other health and social service agencies to help ensure appropriate referrals and service provision.

800.5 Each child under three years of age must be referred to the First Steps Early Intervention Program (FSEIP) within two working days of identification, unless the parent states otherwise. Documentation of the referral must be maintained and include the initial contact date with the family and the date of the referral to the appropriate FSEIP service coordinator.

SECTION E - COMMUNITY LIVING ARRANGEMENTS and COMMUNITY RESPITE SERVICES

This sections applies to both HCBS Waiver and non-HCBS Waiver supervised and supported community living arrangements and community respite services.

Supervised community living arrangements must have staff on site 24 hours a day who are able to respond to a call for assistance in less than five minutes. Supervised community living arrangements include group homes and apartments.

Supported community living provides the necessary staff to support individuals in their own living arrangements in the community. Staff must be on-call 24 hours per day but need not be on site.

Retirement living can be either supported or supervised, depending on the level of support required by the individual.

Community respite services are provided outside an individual's home and provides support to individuals in the absence of their family.

All Community Living Arrangements

900.0 Community Living services include, but not limited to:

a. Supervision;

b. Monitoring of health and physical condition; and

c. Assistance in areas identified by the individual and/or family that may include:

(1) personal hygiene;

(2) housekeeping;

(3) transportation;

(4) community integration activities;

(5) leisure activities;

(6) money management;

(7) shopping; and

(8) cooking, etc.

900.1 Opportunities must be provided for individuals to participate in community activities available to everyone. Documentation of the individual's stated preferences must be maintained in each person's record.

900.2 No more than two individuals may share a bedroom. Each bedroom must be appropriately furnished with a minimum of a single bed and chest of drawers and adequate storage/closet space for each person.

900.3 Each person who is not of retirement age (55 years) must be enrolled in a suitable day activity of their choice (e.g., competitive employment, day habilitation, supported employment, work activity program, etc.). These activities must be coordinated with the community living activities.

~~Supervised Community Living~~

~~910.0 Considering the rights of individuals, each program providing supervised community living services must develop and maintain written rules and regulations that respect each person's privacy, safety, health, and choices.~~

~~910.1* For supervised living, there must be a full-time employee who is:~~

~~a. Designated as the site manager with responsibility for management of the group home or the apartments rented by eligible individuals in an apartment complex;~~

~~b. At least 21 years of age;~~

~~c. Literate;~~

~~d. Licensed to drive in Mississippi; and,~~

~~e. Immediately available on site.~~

~~910.2* Supervised Living programs must have qualified staff on site 24 hours per day. Staff must be able to respond to requests for assistance in less than five minutes.~~

~~910.3* For all new living arrangements certified after July 1, 2002, no more than three individuals may reside in a single apartment or house.~~

~~910.4* For individuals participating in supervised living, there must be at least one staff person available for every six individuals served, depending on each person's identified level of support.~~

~~Supported Living~~

~~920.0* All Supported Living programs must have qualified staff available to assist individuals as determined by each person's required level of support. However, at least one qualified staff person must be on call 24 hours per day to provide assistance/support as required by each individual.~~

~~920.1* Staff must provide personal contact with each individual as defined in each person's Supported Living Service Plan as needed, but at least weekly. For individuals enrolled in the HCBS Waiver, the amount of~~

support from staff members is authorized by each person's HCBS Waiver Support Coordinator.

920.2γ Auditory smoke/fire alarms, with a noise level loud enough to awaken individuals, must be securely mounted and located in the following areas:

a. One unit in the living room; and

b. One unit in each bedroom.

920.3γ There must be at least one fire extinguisher securely mounted in the kitchen.

a. The fire extinguisher must be checked quarterly by staff with documentation of such maintained by the provider. Fire extinguishers are to be serviced at least annually by a qualified service person or company and have a valid service tag attached.

b. All individuals must be trained in the use and operation of the fire extinguisher, upon admission and annually thereafter, and documentation of the training must be maintained in each individual's record.

920.4 Furnishings must be adequate for the number of individuals living in the residence.

920.5* The residence must be maintained in a safe and sanitary manner.

920.6 Persons must maintain their own financial resources according to the following:

a. No money will be received from or given to individuals by staff;

b. No staff or agency name can appear on an individual's personal accounts; and

c. No financial transaction can be made without the presence of the individual.

920.7 For individuals participating in Supported Living, there must be at least one staff person available for every 10 individuals served, depending on each person's identified level of support.

~~Retirement Living~~

~~Retirement Living is appropriate for individuals who are age 55 or older and for whom habilitation planning is no longer appropriate. The standards for supervised and supported community living also apply to Retirement Living. The standards below are in addition to those found in Supervised and Supported Community Living.~~

~~930.0 Persons entering or admitted to retirement living must be at least 55 years old.~~

~~930.1 Documentation must be maintained to indicate individuals are offered choices about the activities they participate in each day. For example, a person may choose to volunteer, continue at the work activity center, or simply stay at home more.~~

~~930.2 Nursing assessments must be conducted at least monthly for each individual to ascertain heath status and assist individual in accessing any needed medical services/supports.~~

SECTION G- Community Respite Services

XVII.G.1. ~~Community Respite Services may be provided in a community program certified by the Department of Mental Health.~~ Community Respite Services are provided to individuals enrolled in the ID/DD Waiver. Community Respite services are designed to provide families/care givers a safe place in the community where they can take their family member on a short-term basis for the purpose of relieving the family or caretaker or to meet planned or emergency needs. Typically, community respite is provided at times when other types of services are not available such as evenings and weekends.

XVII.G.2. The expected outcome for Community Respite Services is that families receive relief from the constant demands of care giving.

XVII.G.3. Community respite services must be provided in a DMH certified site in the community.

XVII.G.4. Community respite cannot be provided over night.

XVII.G.5. Individuals attending a community respite program cannot be left unattended at any time.

XVII.G.6. Individuals must be engaged in chosen activities which are age appropriate during the provision of community respite.

XVII.G.7. Snacks and meals (including drinks must be provided at regular meal times (breakfast, lunch, and dinner). If the person arrives in between meal times, he/she must be offered at least one (1) drink and snack.

XVII.G.8. For every eight (8) 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.

~~940.0* There must be at least two staff for every seven individuals served, depending on the needs of the individuals served.~~

~~940.1 Staff providing community respite services must be at least 21 years of age and literate.~~

~~940.2* Each individual receiving services must be given opportunities to participate in social, cultural, and recreational activities in accordance with their age and interests and relevant to the length and purpose of stay.~~

~~940.3* Persons of similar age must be served during each respite period to facilitate age appropriate interactions.~~

~~940.4* When overnight respite services are offered, no more than three persons may share sleeping quarters, and males and females must sleep in separate rooms.~~

~~940.5* Fire drills with a corresponding written efficiency report must be conducted according to the following:~~

~~a. If a program provides services less than one time per week, drills must be conducted at least monthly, or~~

~~b. If a program provides services at least weekly or on a daily basis, drills must be conducted quarterly.~~

~~940.6 A record must be maintained of all money received and disbursed on the individuals' behalf during the respite stay.~~

~~940.7* Individuals must never be left unattended.~~

~~940.8* If medications are administered during the provision of community respite services, they must be given by qualified personnel as defined in the Nurse Practice Act.~~

~~940.9 During the provision of community respite services, individuals must be offered snacks and meals, as appropriate, during their stay. Meals must be provided at regular meal times (breakfast, lunch, and dinner) if the~~

~~person is present during those times. If a person arrives in between meal times, he/she must be offered at least one drink and snack.~~

SECTION ~~F~~ E- SUPPORTED EMPLOYMENT SERVICES

XVII.E.1. Supported Employment Services ~~programs~~ are designed to increase the independence, community integration, and productivity of individuals through the provision of support services necessary to achieve and maintain competitive employment and/or self employment.. ~~This section applies to both HCBS Waiver and non-HCBS Waiver programs~~.

Competitive employment is defined as having a job in a business (es) in the community where individuals without disabilities are employed. Additionally, supported employment may consist of services to support and/or assist an individual in starting his/her own business.

~~Employment Services may consist of recruitment of individuals from sheltered employment or prevocational programs to competitive employment (either with or without support), job finding services, development of service plans, job analysis, matching the individual to the most appropriate job, on-the-job training, and continuing support to assist the individual in adapting to and maintaining employment. Assistance and support are also provided to the employer in understanding the individual's specific abilities as they relate to the job and in developing natural supports for the individual in the workplace.~~

XVII.E.2. Expected outcomes for Supported Employment Services include:

a. Individuals achieve and maintain community employment.
b. Individuals increase their level of independence.
c. Individuals have increased opportunities for community integration.

XVII.E.3. Supported employment consists of three types of individualized services designed to assist/support an individual in obtaining and maintaining a job in the community. Providers must be able to provide all three aspects of supported employment.

a. Job development and placement;
b. Training/coaching to assist/support the individual in learning the job requirements and how to perform it; and
c. Varying levels/types of ongoing job support necessary for the individual to maintain the job.

~~1000.0 Employment services consist of activities and services/supports required for an individual to obtain and maintain community employment. These activities include, at a minimum:~~

~~a. Job finding;~~

~~b. Job coaching;~~

~~c. Assistance with completing and submitting job applications;~~

~~d. Exploring different job options;~~

~~e. Transportation;~~

~~f. Training; and~~

~~g. On-going support.~~

XVII.E.4. Supported Employment Services:

e. Must provide transportation to conduct job finding activities and to transport the individual to and from his/her job;

f. Are provided in settings where individuals without disabilities are employed;

g. Are only available for individuals who are/will be compensated directly by the employer, 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 people without disabilities;

h. Can be provided in groups of no more than three (3) individuals and one (1) staff person;

e. Cannot be provided in prevocational or work activity programs;

f. Cannot be used to support volunteer work or unpaid internships; and

g. Include personal care/assistance when specified in the individual's supported employment service plan.

~~1000.1 The employment service provider must provide documentation that an annual survey of the labor market has been conducted for use in~~

planning and coordinating placement and training efforts. The survey must include:

a. Names of businesses contacted;

b. Date contact was made;

c. Person(s) contacted;

d. Job type; and

e. Rate of pay for job type.

1000.2* The program must maintain documentation of the development of a Marketing Plan, which must include, but not be limited to, the following:

a. The advantages of employing individuals who have disabilities;

b. The skills and competencies of individuals with disabilities under consideration for placement; and

c. Ways in which work environments can be adapted to facilitate training and employment of individuals with disabilities.

1000.3* Documentation must be maintained by the program to show it provides or arranges for an array of employment and employment training opportunities.

1000.4* Employment opportunities must be provided according to the needs, desires, and preferences of individuals rather than just jobs available.

1000.5 Integration/inclusion in job related social activities must be facilitated by the Employment Specialist to promote natural supports and be documented in Employment Services Contact Summary.

1000.6* The organization must define the selection process for persons to be served. The organization must demonstrate that persons will have access to Employment Services without regard to the severity of their disability.

1000.7* All Employment Service programs must prepare and distribute information to individuals receiving services on policies regarding job loss, transfer, and reentry into the Work Activity Center/Day Habilitation/Prevocational Program. Documentation of dissemination of this information must be maintained in each individual's record.

~~1000.8* Programs providing their own job trainers must:~~

~~a. Develop specifications and/or task analyses in writing to ensure proper training of the individual on the job site;~~

~~b. Provide general and relevant training to the job trainer concerning specifications and/or task analysis for each job; and~~

~~c. Maintain documentation that this training (described in b.) occurs before the job trainer begins working with an individual.~~

~~1000.9 For HCBS Waiver Supported Employment Services, federal financial participation must not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:~~

~~a. Incentive payments made to an employer of individuals receiving services to encourage or subsidize the employer's participation in a supported employment program;~~

~~b. Payments that are passed through to individuals receiving the services of supported employment programs; or~~

~~c. Payments for vocational training that is not directly related to an individual's supported employment program.~~

~~1001.0* Transportation for HCBS Waiver participants will be provided between the individual's place of residence and the site of supported employment services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. Transportation provided must be accessible for persons with disabilities~~.

SECTION ~~G~~ F- ~~HCBS WAIVER~~ SUPPORT COORDINATION SERVICES

~~Support Coordination~~

~~Support coordination services are designed to assist individuals in accessing services in the community which meet their individual needs to prevent or delay placement away from home and/or their community. Support coordination is a pivotal service under the HCBS Waiver. This service is provided by each of the state's five regional centers.~~

~~The HCBS Waiver Support Coordinator has the responsibility of initiating each individual's ongoing assessments, monitoring the condition of enrolled individuals, monitoring all services on each individual's Plan of Care, determining the individual's level of satisfaction with services provided, and assisting individuals in accessing all needed services, regardless of funding source.~~

~~It is the responsibility of the HCBS Waiver Support Coordinator to listen to each person and/or his/her family and arrange services around each individual's stated wishes and desires. A family may not know they need a service called Arespite,@ but they know they need assistance at home because they are exhausted. The HCBS Waiver Support Coordinator must take all available information and, based upon the family's wishes and desires, arrange services and supports that are flexible and tailored to each person. The HCBS Waiver Support Coordinator is to act as an advocate for each person, assisting them in navigating through the various service systems.~~

XVII.F.1. Support coordination services are provided to individuals enrolled in the ID/DD Waiver. Support coordination is designed to coordinate and monitor all services an individual receives, regardless of funding source, to ensure services are adequate, appropriate, and meet individual needs.

XVII.F.2. The expected outcome for Support Coordination Services is that participants in the ID/DD Waiver receive coordinated services to maximize resources in order for them to remain at home and in the community.

XVII.F.3. Support coordinators are responsible for performing the following activities and for maintaining documentation of such in the individual's record:

a. Developing/reviewing/revising each individual's approved plan of care;

b. Informing each individual about all qualified providers for the services on his/her approved plan of care;

c. Submitting all required information for review/approval/denial to the BIDD;

d. Notifying each individual of approval/denial for:

(1) Initial enrollment;
(2) Requests for additional services;
(3) Requests for increases in services;
(4) Requests for recertification of ICF/MR level of care;

e. Notifying each individual of:

(1) Reduction in service(s);

(2) Termination of service(s); and/or
(3) Discharge from the ID/DD Waiver program.

f. Informing and providing the individual/legal representative with the procedures for appealing the denial, reduction, or termination of ID/DD Waiver services, discharge from the ID/DD Waiver, or determination of ineligibility due to not meeting intermediate care facility for the mentally retarded (ICF/MR) level of care requirements.

g. Locating and gaining access to all services listed on the plan of care, regardless of funding source;

h. Ongoing monitoring and assessment of the individual's plan of care 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 if there is a need for any new services (ID/DD Waiver and others) based upon expressed needs or concerns or changing circumstances;
(4) Information addressing whether the amount/frequency of service(s) listed on the approved plan of care remains appropriate;and
(5) Review of service plans developed by agencies which provide ID/DD Waiver services to the individual.

i. Ensuring all services a person receives, regardless of funding source, are coordinated to maximize the benefit for the individual and to prevent duplication of services;

j. Performing all necessary functions for the individual's annual recertification of ICF/MR level of care;

k. Conducting at least quarterly face-to-face visits with each individual according to BIDD requirements; and

l. Making phone contacts at the frequency required by BIDD.

~~1100.0* HCBS Waiver Support Coordinators and HCBS Waiver Support Coordination Directors cannot supervise or provide any other HCBS Waiver services.~~

XVII.F.6. Support coordinators cannot supervise or provide any other ID/DD Waiver service. Support coordination services must be distinctly separate from other ID/DD Waiver service(s) an agency provides.

~~1100.1 The HCBS Waiver Support Coordinator is responsible for linking the family with the Diagnostic Services Department and for assisting in arranging for the initial assessment for eligibility.~~

~~1100.2* During the preadmission evaluation process, the HCBS Waiver Support Coordinator must verify the individual's eligibility for Medicaid. If an individual who is interested in receiving HCBS Waiver services is not currently eligible for Medicaid, the HCBS Waiver Support Coordinator must assist the person in applying for Medicaid, if appropriate.~~

~~1100.3* The HCBS Waiver Support Coordinator must assist the individual in locating and gaining access to services listed on the Plan of Care as well as other Medicaid State Plan services and all other services, regardless of funding source, with documentation of such in the Support Coordination Contact Summaries.~~

~~1100.4 The HCBS Waiver Support Coordinator must notify in writing the State HCBS Waiver Director if a service provider fails to submit required documentation according to time lines established in the~~ Bureau of Mental Retardation Record Guide ~~for each service.~~

~~1100.5* If, at any time, a person's condition changes so that the HCBS Waiver is no longer the appropriate program to meet the individual's needs (either the person no longer requires ICF/MR level of care as determined by the interdisciplinary team, or the person requires a level of care greater than what can be provided through the HCBS Waiver, as determined by the interdisciplinary team), the HCBS Waiver Support Coordinator must:~~

~~a. Notify the individual/legal representative in writing of:~~

~~(1) the recommendations made by the interdisciplinary team;~~

~~(2) the reasons why the recommendations were made; and~~

~~(3) information about all other available service options.~~

~~b. Assist the individual in locating appropriate services;~~

~~c. Submit a justification for the discharge and a discharge plan to the State HCBS Waiver Director for approval at least 10 calendar days prior to the anticipated discharge date; and~~

~~d. Complete the Recipients Admitted and Discharged form (HCBS-105) within 10 calendar days of notification of discharge approval and submit the colored carbon copies as directed on the form.~~

~~1100.6 If a person is discharged from the HCBS Waiver because he/she: 1) is ineligible for Medicaid; 2) is admitted to an ICF/MR or Nursing Facility (NF); 3) requests discharge; 4) moves out of state; 5) is hospitalized for more than 30 days; 6) allows his/her current certification to lapse; or 7) dies, the HCBS Waiver Support Coordinator must do the following:~~

~~a. Submit the HCBS-105 form, as directed on the form, within seven calendar days of the discharge date;~~

~~b. Complete a Termination Summary within seven calendar days of the discharge and place in the individual's record; and~~

~~c. Within fifteen days of the close of the fiscal year (July 15), submit all Termination Summaries for people whose status remained discharged until July 1, to the State HCBS Waiver Director.~~

XVII.F.4. 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.

XVII.F.5. ~~1100.7*~~ The maximum caseload for ~~each HCBS Waiver~~ a Support Coordinator ~~cannot exceed~~ is 35 ~~eligible individuals~~. waiver participants

~~1100.8 If a person is eligible for and desires supported employment services rendered under the HCBS Waiver, the HCBS Waiver Support Coordinator must maintain documentation in each individual's file that the service is not otherwise available under a program funded by either the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act.~~

~~1100.9 The HCBS Waiver Support Coordinator must maintain a waiting list for services, if necessary. The service waiting list is for those persons deemed eligible for HCBS Waiver services but for whom a qualified service provider(s) cannot be located.~~

~~1101.0 The HCBS Waiver Support Coordinator must maintain documentation of efforts to locate qualified service providers in the contact summaries in each person's record.~~

XVII.F.7. Support coordinators are responsible for maintaining electronic files as required by the BIDD.

~~Attendant Care Services~~

~~Attendant Care Services are provided by a Certified Nurses' Aid (CNA) who is on the register for such, someone who has completed a Nurse Aid Training program and has documentation of such, someone who has completed the Direct Care Worker Training program, or someone approved by the DMH for service provision to a particular individual.~~

~~Providers of attendant care services must meet the applicable standards in Part II - Organization and Management, Part III - Human Services (except Section A), Part IV, Section A (General Standards), and Section G (HCBS Waiver Services, Attendant Care Services).~~

~~Attendant care services are provided to meet daily living requirements and to ensure adequate support for optimal functioning at home or in the community.~~

~~1110.0* Depending on each individual's needs and as specified on the Plan of Care, attendant care services may include, but not be limited to:~~

~~a. Support for activities of daily living such as bathing (sponge, tub), personal grooming and dressing, personal hygiene, toileting, transferring, assisting with ambulation, etc;~~

~~b. Assistance with housekeeping that is directly related to the individual's disability and which is necessary for the health and well-being of the individual (e.g., changing bed linens, straightening area used by individual, doing the personal laundry of the individual, preparation of meals for the individual, cleaning the individual's equipment such as wheelchairs, walkers, etc.);~~

~~c. Food shopping, meal preparation and assistance with eating, not including the cost of the meals themselves; and/or~~

~~d. Support for community participation by accompanying and assisting the individual as necessary to access community resources and support for participating in community activities,~~

~~including appointments, shopping, and community recreation/leisure resources, and socialization opportunities.~~

~~1110.1γ Attendant care services are non-medical and involve no nursing skills.~~

~~Respite Services~~

~~Respite services are defined as a service provided to an individual on a short-term basis for the purpose of relieving the family or caretaker or to meet planned or emergency needs. Respite care may be provided in an individual's home, in a certified Community Respite Program, or in an ICF/MR.~~

~~*In-Home Nursing Respite*~~

~~In-home nursing respite must be provided by a Licensed Practical Nurse (LPN) or Registered Nurse (RN). The need for nursing respite is dependent upon whether or not the individual requires nursing care (as defined in the Nurse Practice Act) in the absence of the caretaker.~~

~~*In-Home Companion Respite*~~

~~In-home companion respite must be provided by a Certified Nurses' Aide (CNA) who is on the register for such, someone who has completed a Nurse Aid Training program and has documentation of such, someone who has completed the Direct Care Worker Training program, or someone approved by the DMH for service provision to a particular individual.~~

~~*In-Home Nursing or Companion Respite Provided by a Program/Agency*~~

~~Programs/agencies which provide in-home nursing or companion respite services must meet the applicable standards in Part II - Organization and Management, Part III - Human Services (except Section A), and Part IV - Section A (General Standards) and Section G (HCBS Waiver Services, In-Home Respite, except 1120.0, 1120.1, and 1120.2). Companion respite may only be provided by a program/agency certified by the DMH.~~

~~*In-Home Nursing Respite or Companion Respite Provided by Self-Employed Nurses*~~

~~Nurses who are self-employed must: (1) adhere to the record keeping and confidentiality requirements found in the Bureau of Mental Retardation Record Guide and the standards in Part II, Section E-Training and Staff Development, Part IV, Section A-General Standards and Section G-HCBS Waiver Services, In-Home Respite; (2) annually sign an agreement with the Department of Mental Health; and, (3) obtain their own Mississippi Medicaid provider number.~~

1120.0* A self-employed nurse must submit a written application, along with the information listed below, to the HCBS Waiver Support Coordination Director at the appropriate regional center.

a. Mississippi Medicaid Provider number (if he/she already has one);

b. Names, addresses, and daytime phone numbers of at least two personal and two professional references. At least two of the professional references must be a current or past supervisor;

c. Copy of valid Mississippi driver's license;

d. Copy of current CPR card;

e. Copy of TB skin test results, current within one year; and

f. Copy of his/her nursing license, verifiable by the State Board of Nursing. The service provider may not have any disciplinary or criminal action pending against them.

1120.1* Self-employed LPN's and RN's must have an interview with the appropriate HCBS Waiver Support Coordinator. He/she must give permission for an annual criminal records check. The appropriate regional center will submit the necessary forms to the appropriate law enforcement agency(ies), but the self-employed nurse is responsible for any and all fees. No services may be provided until the initial report indicating there is no evidence of criminal activity is received back by the HCBS Waiver Support Coordinator. If subsequent annual checks reveal any evidence of criminal activity, the self-employed nurse will immediately be taken off any cases on which he/she is working.

1120.2* Annually, self-employed LPN's or RN's must sign an agreement for the provision of in-home respite services with the Department of Mental Health and submit copies of their nursing licenses, CPR cards, TB skin test results, and documentation of required annual and quarterly training.

1120.3* In-home respite services may include:

a. Assistance with personal care needs such as bathing, dressing, grooming, toileting;

b. Assistance with feeding;

c. Assistance with transferring/ambulation;

d. Play/leisure/socialization activities;

e. Administration of prescription medication according to the Nurse Practice Act;

f. Taking the individual on an outing in the community; and/or

g. Other activities specified on the Activity Plan.

1120.4* Individuals are not to be left unattended at any time during the provision of in-home respite services.

1120.5* Medicine and other medical treatments can only be administered according to the Mississippi Nurse Practice Act.

Community Respite (See Part IV, Section E Community Living Arrangements and Community Respite.)

HCBS Waiver Community Respite Services may be provided in a community program certified by the Department of Mental Health. Community Respite services are designed to provide families/care givers a safe place in the community where they can take their family member on a short-term basis for the purpose of relieving the family or caretaker or to meet planned or emergency needs.

Community Respite providers must meet the applicable standards in Part II - Organization and Management, Part III - Human Services (Sections A through G), and Part IV- Section A (General Standards and Section E - Community Living Arrangements and Community Respite Services).

ICF/MR Respite

ICF/MR Respite must be provided in a facility licensed as such by the State of Mississippi. A copy of the ICF/MR license must be provided to the DMH before services begin.

1130.0* ICF/MR Respite Services may be provided up to 30 days (720 hours) during the fiscal year per individual. The individual must normally live at home under the daily care of family members or foster family members.

1130.1* The facility must submit its current procedures for the provision of short-term respite services. The procedures for individuals receiving HCBS Waiver services must be the same as for individuals typically receiving respite services.

~~1130.2* The facility must sign an agreement with the DMH and maintain this documentation on file to assure they will adhere to all ICF/MR regulations as well as these standards and any other requirements of the DMH.~~

~~1130.3* ICF/MR respite services may only be provided to individuals for whom it is an approved service on their Plan of Care and only for the amount of time specified on the Plan of Care. The HCBS Waiver Support Coordinator must authorize the provision of ICF/MR respite services.~~

~~1130.4* ICF/MR respite providers must submit copies of the following to the HCBS Waiver Support Coordinator by the 15th of the month following the month in which the respite stay ended:~~

~~a. The individual habilitation/program plan;~~

~~b. Progress notes;~~

~~c. Any other documentation needed to verify the respite stay; and~~

~~d. HCFA-1500 claim forms.~~

SECTION B- DAY SERVICES- ADULT ~~Day Habilitation~~
(referred to as Day Habilitation in 2002 Revision of DMH Standards)

~~Day Habilitation services provide opportunities and activities for individuals to attain outcomes related to daily living, social, communication, self-help, and other adaptive skills. Activities provide opportunities for developing and increasing personal care skills, enhancement and development of social and interpersonal skills, and encouragement and support for individualized activities in the community. Day habilitation cannot be used to supplant mandated educational services for school age persons.~~

~~Activities for individuals must be planned on the basis of his/her interests, likes, dislikes, length of time he/she would like to participate each day, special rest periods, size of group in which he/she can function and relate to best, requirements for individual attention, special limitations of activities, diet, etc.~~

~~Providers of Day Habilitation services for adults must meet the applicable standards in Part II -Organization and Management, Part III - Human Services, and Part IV - Section A (General Standards) and Section G (HCBS Waiver Services, Day Habilitation).~~

XVII.B.1. ID/DD Waiver day services for adults are designed to foster greater independence, personal choice, and improvement/retention of self-help, socialization, positive

behavior, and adaptive skills. Services are provided in a community-based setting. A central component of the service is to provide opportunities for individuals to become more independent, productive, and integrated in their community.

XVII.B.2. The expected outcomes for Day Services – Adult include the following:

a. Individuals are engaged in person-centered planning.
b. Individuals are engaged in meaningful activities and community integration opportunities.

XVII.B.3. Day services for adults must include the following services/activities:

a. Administration of a functional skills assessment using instrument(s) specified by BIDD;

b. Development of a service plan based on information from the functional skills assessment as well as other information provided by the individual/legal representative to ensure his/her choices/desired outcomes are addressed;

c. Transportation to and from an individual's residence and as necessary to participate in chosen activities away from the certified day services for adults program.

d. Personal care which includes providing direct supports and/or supervision/assistance in the areas of personal hygiene, eating, communication, mobility, toileting, and/or dressing to increase the individual's ability to participate in the community;

e. Daily opportunities for varied activities, both passive and active;

f. Opportunities to make choices about the activities in which he/she participates;

g. Implementation of positive behavior support plans when appropriately trained by a behavior support/interventionist.

h. Assistance in using communication and mobility devices when indicated in the individualized assessment and service plan.

XVII.B.4. Day Services for adults may take place in the community and/or in a DMH certified site. Additionally:

e. Certified facilities must be open at least five (5) days per week, six (6) hours per day;

f. A minimum of fifty (50) square feet of usable space must be available per each individual in the program. Additional square footage may be required for individuals who use wheelchairs.

g. Planned activities must be available during normal program hours;

h. Community integration opportunities must be offered at least weekly and address at least one of the following:

(1) Activities which address daily living skills/needs; or

(2) Activities which address leisure/social/other community events.

.

e. All community integration activities must be based on choices/requests of the individuals served and documentation addressing the choices offered and the chosen activities must be maintained in each person's record.

XVII.B.5. 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.

XVII.B.6. When providing opportunities for community inclusion, there must be at least one (1) staff person for every four (4) people, if none of the four (4) requires mobility assistance. If anyone in a group of four (4) requires mobility assistance, there must be at least two (2) staff for the group of four (4) people. Depending on individual requirements for support, additional staff may be required.

XVII.B.7. A person cannot be excluded from participating in community activities because he/she requires one-on-one assistance.

~~1140.0* Programs must be able to accommodate a wide range of needs (e.g., ambulatory, verbal people to non-ambulatory, non-verbal people who may need suctioning and/or be fed through a G-tube, etc.). Eligible individuals cannot be denied services from the program of their choice based on the severity of their disability.~~

~~1140.1* Day habilitation services are designed based upon the individual's interests, desires, wishes, and personal outcomes. The services provided must be based on the requirements of the individuals served rather than on~~

~~the availability of services. Day habilitation services include, but are not limited to, the following:~~

~~a. Provision of personal care services and activities of daily living, such as assistance with walking, grooming, eating and toileting;~~

~~b. Activities that promote personal growth and enhance the person's self-image;~~

~~c. Participating in activities that promote independence;~~

~~d. Developing interpersonal relationships that are safe and wanted by the individual;~~

~~e. Developing creative capacities;~~

~~f. Improving physical and emotional well being;~~

~~g. Being exposed to and involved in activities and events within the greater community; and~~

~~h. Experiencing cultural enrichment, etc.~~

XVII.B.10. ~~1140.2*~~ The program is responsible for ensuring that each individual receives a minimum of one midmorning snack, one nutritious noon meal, and one mid-afternoon snack. Individuals must be offered choices about what they eat and drink.

~~1140.3* Transportation must be provided between the individual's place of residence and the day habilitation site, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. Transportation that is accessible for persons with disabilities must be provided.~~

~~1140.4* Planned activities must be available whenever the program is in operation. The program must be in operation a minimum of six hours per day, five days per week. The maximum amount of billing per day is six hours per person.~~

~~1140.5* Opportunities for community integration of individuals receiving services with individuals without disabilities in normal activities must be provided at least weekly, but more often as indicated by each person, and be documented in each person's record.~~

~~1140.6*~~ ~~Community outings must take place with a group of no more than three individuals at a time with at least one staff person, depending on each person's identified level of required support. The program must provide the level of staff necessary to ensure the health and welfare of the individuals and cannot exclude individuals because they require one-on-one assistance.~~

XVII.B.8. ~~1140.7*~~ Equipment and materials in the program must be appropriate for adults. There must be an adequate supply of materials to ensure each person is able to engage/participate in a chosen activity at any time.

~~used must be age and size appropriate for each person. The program is responsible for securing equipment/supplies that allow individuals to attain their desired outcomes, including equipment/ supplies that are necessary to enable the individual to fully participate in desired activities. This may include, but not be limited to: adaptive seating, adaptive feeding supplies, safety equipment, etc.~~

XVII.B.9. The program must provide equipment (e.g., adaptive seating, adaptive feeding supplies, safety equipment, etc.) which allows individuals to address activities contained in their service plan as well as other equipment which might be necessary to allow the individual to successfully participate in chosen activities.

~~1140.8*~~ ~~There must be daily opportunities for varied activities, active and passive, and for the individual to make choices about the activities in which he/she participates.~~

~~1140.9*~~ b. A minimum of 50 square feet of usable space per person must be maintained. Additional square footage may be required for people who use wheelchairs.

~~1141.0~~ ~~Day habilitation programs must be located where there are opportunities for community integration activities that assist the individual in accessing, participating in, and becoming familiar with his/her local community.~~

~~1141.1*~~ ~~There must be at least two staff assigned to provide center-based care for every seven people receiving day habilitation. Depending upon the physical capabilities of the individuals served, additional staff may be required.~~

~~1141.2*~~ ~~The program must maintain documentation of training of program staff by certified speech/language pathologists, registered occupational therapists, registered physical therapists, and/or certified behavior support/~~

~~interventionists in order to coordinate and incorporate these services in the individualized habilitation plan and daily activities.~~

~~1141.3* Only a licensed health care professional can provide nursing care, medical services, or medication.~~

SECTION C- Prevocational Services

~~Prevocational services consist of a range of activities designed to lead to vocational skill development. Prevocational services can be either center-based or community-based. Community-based services are provided in sites typically used by others in the community which promote individual inclusion and independence in the community. Center-based services are provided in certified work activity centers.~~

~~If the eligible individual engages in any form of compensable work as a necessary but subordinate part of habilitation services, the program must be a certified work activity center in accordance with Section 14(c) the Fair Labor Standards Act and the Minimum Standards for Community Mental Health/Mental Retardation Services and receive compensation according to those requirements. If an individual is making more than 50% of the minimum wage, his/her participation in prevocational services must be reevaluated.~~

~~Activities included in this service are not primarily directed at teaching specific job skills, but at underlying habilitative goals, such as attention span and motor skills. The ultimate outcome is for each person to obtain and maintain community employment. All prevocational services will be reflected in the individual's Plan of Care as directed to habilitative, rather than explicit vocational skill objectives.~~

~~Documentation will be maintained in the file of each individual receiving this service that the service is not otherwise available under a program funded under the Rehabilitation Act of 1973 or the Individuals with Disabilities Education Act (IDEA).~~

~~Providers of Prevocational Services must meet the applicable standards in Part II – Organization and Management, Part III – Human Services, and Part IV – Section A (General Standards), Section C (Work Activity Services), and Section G (HCBS Waiver Services, Prevocational Services).~~

XVII.C.1. Prevocational services are provided to persons not expected to be able to join the general workforce within one year (excluding supported employment programs). Activities are not primarily directed at teaching specific job skills, but at underlying skills which are useful in obtaining community employment. Prevocational services are available to individuals who are no longer eligible for educational services based on their graduation and/or receipt of diploma/equivalency certificate and/or their

permanent discontinuation of educational services within the parameters established by the Mississippi Department of Education.

XVII.C.2. The expected outcome for Pre-Vocational Services is that individuals will develop the skills necessary to obtain and maintain community employment.

~~1150.0* The services provided and provision of training as specified in the habilitation plan must be based on the requirements of the individual rather than on the availability of services.~~

~~1150.1* Transportation must be provided between the individual's place of residence and the site of the prevocational services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. Transportation that is accessible for persons with disabilities must be provided.~~

~~1150.2* Prevocational Services include, but are not limited to:~~

~~a. Specialized supervision to ensure the individual's health and safety;~~

~~b. Activities that promote following directions, adapting to work routines, and carrying out assigned duties in an effective and efficient manner;~~

~~c. Activities that promote acquiring appropriate attitudes and work habits, including instruction in socially appropriate behaviors on and off job sites, and socially appropriate hygiene and grooming activities;~~

~~d. Activities that assist the individual in adjusting to the productive and social demands of the workplace;~~

~~e. Familiarizing the individual with job production and performance requirements;~~

~~f. Providing mobility training, including the utilization of public transit systems; and~~

~~g. Activities that allow opportunities to become familiar with the appropriate use of job-related facilities (e.g., break areas, lunch rooms/cafeterias, and restrooms).~~

XVII.C.10. ~~1150.3*~~ The program must be in operation a minimum of five days a week and at least six hours a day. ~~The maximum amount of billing per day is six hours per person.~~

~~1150.4* There must be appropriate opportunities for community integration and exposure to work experiences outside the center-based setting. This must be documented in each person's record. If a person chooses not to participate in such activities, this must also be noted. Even if a person initially declines, the program staff must continue to offer opportunities and options for community integration and employment.~~

~~1150.5* Community integration activities must take place with a group of no more than three individuals at a time with at least one staff person, depending on each person's identified level of required support. The program must provide the level of staff necessary to ensure the health and welfare of the individuals and cannot exclude individuals because they require one-on-one assistance.~~

~~1150.6* The program must determine and document each individual's need and desire for community employment placement annually and make referrals to and/or provide supported employment services when desired by the individual.~~

~~1150.7 Persons who obtain community employment and are terminated from the program shall be guaranteed a position in the prevocational services program as soon as an opening is available.~~

~~1150.8* There shall be at least one staff assigned to provide center-based care for every six people receiving prevocational services, depending upon the physical capabilities of the individuals.~~

XVII.C.3. Prevocational services must be provided in a certified work activity center that meets all the requirements of the U.S. Department of Labor.

XVII.C.4. The provider must administer a functional skills assessment using instruments specified by BIDD.

XVII.C.5. The provider must develop a service plan, based on information from the functional skills assessment as well as information provided by the individual/legal representative, to ensure his/her choices/desired outcomes are addressed.

XVII.C.6. Based on the results of the individualized assessment and as indicated on the service plan, prevocational services must provide the following:

a. Transportation between the individual's place of residence and the site of the prevocational services, and/or on community outings/job exploration;

b. Instruction in basic safety principles according to his/her current activities in the program;

c. A realistic work atmosphere;

d. Encouragement and support of good work habits;

e. Teaching/demonstration of the proper care and handling of equipment, materials, tools, and machines;

f. Teaching/encouragement of appropriate responses to requests from supervisors and/or co-workers;

g. Addressing issues such as punctuality, safe work practices, following directions, attending to tasks, problem solving, social skills appropriate for the work place, and use of small appliances;

h. Personal care/assistance, but it may not comprise the entirety of the service; and

i. Opportunities for community integration and exposure to work experiences (job exploration) outside the center-based setting and which must:

(1) Be offered to each individual at least one time per month and be documented in his/her record;

(2) Take place with a group of no more than four individuals at a time with at least one staff person, depending on each person's identified level of required support;

(3) Provide the level of staff necessary to ensure the health and welfare of the individuals; and

(4) Include individuals who may require one-on-one assistance.

XVII.C.7. If an individual begins earning more than fifty percent (50%) of the minimum wage, the individual, appropriate staff, and the ID/DD Waiver Support Coordinator must review the necessity and appropriateness of prevocational services.

XVII.C.8. The program must have a "Return to Prevocational Services" policy which ensures individuals who leave the program to work in the community can return to the program if their community job ends.

XVII.C.9. 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 (see Standard VI.C.1 (c)).

XVII.C.11. The program must ensure it will make available lunch and/or snacks for individuals who do not bring their own.

SECTION I- Behavior Support/Intervention Services

Behavior Support/Intervention provides behavior support/intervention services for individuals who exhibit behavior problems ~~that prevent them from benefitting~~ f which cause them not to be able to benefit from other services being provided or cause them to be so disruptive in their environment(s) that there is imminent danger of ~~institutionalization~~. causing harm to themselves or other. ~~The behavior support/interventionist works directly with the individual and also trains staff and family members to assist them in implementing/maintaining specific portions of the behavior support/intervention program in accordance with standards in Part III, Section C - Rights of Individuals Receiving Services.~~

~~*Behavior Support/Intervention Services Provided by a Program/Agency*~~

~~Programs/agencies which provide behavior support/intervention services must meet the applicable standards in Part II - Organization and Management, Part III - Human Services (except Section A), and Part IV - Section A (General Standards) and Section G (HCBS Waiver Services, Behavior Support/Intervention, except 1160.0, 1160.1, and 1160.2).~~

~~*Behavior Support/Intervention Services Provided by Self-Employed Providers*~~

~~Behavior Support/Interventionists who are self-employed must: (1) adhere to the record keeping and confidentiality requirements found in the Bureau of Mental Retardation Record Guide; (2) adhere to the Minimum Standards in Part II, Section E-Training and Staff Development; Part III, Section C - Rights of Individuals Receiving Services; and Part IV, Section A-General Standards and Section G-HCBS Waiver Services, Behavior Support/Intervention; (3) annually sign an agreement with the Department of Mental Health; and (4) obtain their own Mississippi Medicaid provider number.~~

~~1160.0* Behavior Support/Interventionists must submit an application and the following required documentation to the DMH/BMR:~~

~~a. Mississippi Medicaid Provider number (if s/he already has one);~~

b. The names, addresses, and daytime phone numbers of at least two personal and two professional references. At least two of the professional references must be a current or past supervisor who supervised the applicant in the development and implementation of behavior support/intervention programs;

c. Copy of valid Mississippi driver's license;

d. Copy of current CPR card;

e. Copy of TB skin test results, current within one year;

f. Copy of: 1) a current license to practice medicine or psychology, verifiable by their respective licensing entity; or 2) a copy of a current license to practice social work license indicating the person is a licensed clinical social worker; or 3) documentation that the person holds a Mississippi Department of Mental Health credential.

g. Documentation of at least four years experience in developing and implementing behavior support/intervention programs for persons with mental retardation; and

h. Documentation of training in the use of physical behavior management or crisis intervention techniques from an approved program.

1160.1* Annually, Behavior Support/Interventionists must sign an agreement for the provision of behavior support/intervention services with the Department of Mental Health and submit copies of their current CPR cards, TB skin tests, Department of Mental Health credentials, or other applicable licenses.

1160.2* The Behavior Support/Interventionist must not have any disciplinary or criminal action pending against them. The Behavior Support/Interventionist must give permission for an annual criminal records check. The appropriate regional center will submit the necessary forms to the appropriate law enforcement agency(ies), but the Behavior Support/Interventionist is responsible for any and all fees for the background check. No services may be provided until the initial report indicating there is no evidence of criminal activity is received back by the HCBS Waiver Support Coordinator. If subsequent annual checks reveal any evidence of criminal activity, the provider will immediately be taken off any cases on which he/she is working.

~~1160.3* To receive behavior support/intervention services, there must be evidence that the person poses a threat to him/herself or others and/or is in imminent danger of institutionalization because of the severity of the behavior(s). The HCBS Waiver Support Coordinator must gather information from the family and/or service providers to justify the request for behavior support/ intervention services. The justification and request for behavior support/intervention services must be submitted to the State HCBS Waiver Director along with the original Plan of Care.~~

~~1160.4* Upon receiving a referral, the Behavior Support/Interventionist must determine if a Behavior Support Plan is appropriate/necessary. This determination must include, at a minimum, the following documentation:~~

~~a. A physical evaluation that is conducted by a physician in order to rule out medical reasons/diagnoses that might be causing the behavior;~~

~~b. An assessment of the individual's environment(s) where the behavior(s) occurs, identification of antecedents of the behavior(s), consequences of the behavior(s), factors that maintain the behavior(s), frequency of the behavior, and how the behavior(s) impact the individual's environment and life; and~~

~~c. A determination as to whether the behavior(s) poses a risk to the health and welfare of the individual or others in the environment~~(s).

~~1160.5* If it is determined that a Behavior Support Plan is appropriate/necessary, the provider develops a Behavior Support Plan, based on the information gathered in Standard 1160.4. In day and residential programs, the Behavior Support Plan must be approved in writing by a committee consisting of, at a minimum:~~

~~a. The parent(s)/legal representative;~~

~~b. The individual;~~

~~c. The QMRP for the service; and~~

~~d. The Executive Director of the program/agency.~~

~~If the individual is not enrolled in a day or residential program, the parents must approve the Behavior Support Plan in writing.~~

~~1160.6* Written parental consent must be obtained before implementing any Behavior Support Plan.~~

~~1160.7* The Behavior Support Plan must include, at a minimum, the following components:~~

~~a. Identifying data;~~

~~b. Behavior(s) to be addressed;~~

~~c. Reduction criteria;~~

~~d. Initiation date and estimated date of completion;~~

~~e. Scheduled dates for review of the plan, at a minimum weekly, to determine if reduction criteria is being met;~~

~~f. Name(s) of individual(s) responsible for implementing the plan;~~

~~g. Materials;~~

~~h. Implementation schedule (e.g., 24 hours/day, only at work, only at home, only at school, etc.); and~~

~~i. Steps and methods for implementing the plan, including risk containment strategies, if needed, and documentation that the interventions show a Aleast to most@ pattern of intrusiveness for the procedures and techniques and meet the requirements of standards in Part III, Section C-Rights of Individuals Receiving Services.~~

~~1160.8 The Behavior Support/Interventionist is responsible for ensuring that data is collected and maintained concerning the reduction of targeted behaviors each day services are provided until the plan is completed.~~

~~1160.9* The Behavior Support/Interventionist must maintain documentation in the individual's record indicating who received training from the Behavior Support/Interventionist regarding maintenance of the plan. The Behavior Support/Interventionist must provide inservice training in the environment(s) in which the plan is to be implemented and maintained in accordance with standards in Part III, Section C - Rights of Individuals Receiving Services.~~

~~1161.0* The Behavior Support/Interventionist is responsible for monitoring the continuing effectiveness of the plan at intervals established in the Behavior Support Plan, but at least weekly, until the plan is completed.~~

XVII.I.1 The expected outcome for Behavior Support and Intervention Services is for people to receive training and supports necessary to decrease maladaptive behaviors which interfere with individuals remaining at home and in the community.

XVII.I.2. Behavior Support and Intervention Services must include the following:

a. Assessing the individual's environment and identifying antecedents of particular behaviors, consequences of those behaviors, and maintenance factors for the behaviors;

b. Developing a positive behavior support plan;

c. Implementing the plan, collecting data, and measuring outcomes to assess the effectiveness of the plan;

d. Training staff and/or family members to maintain and/or continue implementing the plan;

e. Assisting the individual in becoming more effective in controlling his/her own behavior either through counseling or by implementing the behavioral support plan; and

f. Documentation of collaboration with medical and ancillary therapies to promote coherent and coordinated services addressing behavioral issues and to limit the need for psychotherapeutic medications, when applicable.

XVII.I.3. The Behavior Support Plan must be approved in writing as follows:

a. In day and residential programs, the behavior support plan must be approved by the following:

(1) The parent(s)/legal representative;
(2) The individual (if appropriate);
(3) The behavior support/interventionist;
(4) The director of the service; and
(5) The Executive Director of the program/agency or his/her designee.

c. If the individual is not enrolled in a day or residential program, the behavior support plan must be approved by the following:

(1) The parent(s)/legal representative;
(2) The individual (if appropriate); and
(3) The behavior support/interventionist.

XVII.I.4. Behavior Support and Intervention Services provided through the ID/DD Waiver cannot be provided in a public school setting. However, part of the assessment may include observing the person in the classroom setting.

a. The behavior support provider may not function as an assistant in the classroom by providing direct services.

b. If a behavior program is being implemented in the school setting by school personnel, the behavior support provider must document in the record the methods by which all parties are collaborating to ensure consistency of methods and agreement about outcomes.

~~Physical Therapy, Occupational Therapy and Speech/Language/Hearing Services~~

~~1170.0* Providers of physical therapy, occupational therapy, and speech/language/hearing therapy must be licensed according to state law and provide services as specified in their respective practice acts and regulations.~~

~~1170.1* Providers of physical therapy, occupational therapy, and speech/language/hearing therapy must be an approved Medicaid Provider.~~

~~1170.2 Physical therapy, occupational therapy, and speech/language/hearing therapy are available through the HCBS Waiver in a setting not normally covered under the regular Medicaid state plan services (e.g. a day habilitation setting, the home, etc.).~~

~~1170.3 Physical therapy, occupational therapy, and speech/language/hearing therapy must be provided based on the results of evaluations conducted by qualified professionals.~~

~~1170.4* Providers of physical therapy, occupational therapy, and speech/language/hearing therapy must obtain a Service Authorization from each individual's HCBS Waiver Support Coordinator before he/she can begin providing services. Only the amount of service authorized may be provided~~. Any ~~reimbursement received for amounts of time that exceed the Service Authorization will be recouped.~~

~~1170.5* Providers of physical therapy, occupational therapy, and speech/language/hearing therapy must adhere to the time lines and requirements established~~

in the Physical Therapy, Occupational Therapy, and Speech/Language/ Hearing Therapy Section of the Bureau of Mental Retardation Record Guide.

1170.6 All therapy providers must adhere to the record keeping requirements for therapy services found in the Bureau of Mental Retardation Record Guide.

SECTION H - CREATIVE COMMUNITY OPPORTUNITIES (CCO)

Creative Community Opportunities (CCO) is a section of the Minimum Standards for Community Mental Health/Mental Retardation Services that promotes community inclusion and community integration for individuals with developmental disabilities and supports families who have members with developmental disabilities. Services funded under this section may not fit into other sections of the Minimum Standards such as community living, employment, child development, etc. because of the nature of service design. CCO services/supports may include one time projects, product development, special focus initiatives, and/or short term demonstration projects.

According to the purpose of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (PL 106-402), individuals with developmental disabilities and their families are assured participation in the design of, and have access to, needed community services, individualized supports, and other forms of assistance that promotes self-determination, independence, productivity, and integration and inclusion in all facets of community life.

1200.0* All recipients of funding must have measurable service outcomes and performance targets clearly stated in their proposal. During monitoring visits, documentation of specific service outcomes must be provided in measurable terms that relate to the Areas of Emphasis listed in Standard 1200.1.

1200.1 All services funded through the Mississippi Council on Developmental Disabilities (CDD) must address one or more of the following Administration on Developmental Disabilities Areas of Emphasis and provide performance target data identified under each Area of Emphasis.

a. QUALITY ASSURANCE (QA) - People have the information, skills, opportunities, and supports to live free of abuse, neglect, financial and sexual exploitation, and violations of their human and legal rights. The term Aquality assurance@ means advocacy, capacity building and system change activities that result in an

~~improved quality of life for people with developmental disabilities and families.~~

~~(1) reference QA01 People benefitting from quality assurance efforts of the Council in community placements~~

~~(2) reference QA02 Dollars leveraged for quality assurance programs~~

~~(3) reference QA03 Quality assurance programs/policies created/improved~~

~~(4) reference QA04 People facilitated quality assurance~~

~~(5) reference QA05 People trained in quality assurance~~

~~(6) reference QA06 People active in systems advocacy about quality assurance~~

~~reference QA06A Self-advocates active in systems advocacy about quality assurance~~

~~reference QA06B Family members active in systems advocacy about quality assurance~~

~~reference QA06C Others active in systems advocacy about quality assurance~~

~~(7) reference QA07 People trained in systems advocacy about quality assurance in community placements~~

~~reference QA07A Self-advocates trained in systems advocacy about quality assurance~~

~~reference QA07B Family members trained in systems advocacy about quality assurance~~

~~reference QA07C Others trained in systems advocacy about quality assurance~~

~~(8) reference QA08 People trained in leadership, self-advocacy, and self-determination~~

~~(9) reference QA09 People attained membership on public and private bodies and other leadership coalitions~~

~~(10) reference QA10 Other Performance Target Description~~

b. EMPLOYMENT (EM) – People get and keep employment consistent with their interests, abilities and needs.

(1) reference EM01 Adults have jobs of their choice through Council efforts

(2) reference EM02 Dollars leveraged for employment

(3) reference EM03 Employers provided vocational supports to students on the job

(4) reference EM04 Businesses/employers employed adults

(5) reference EM05 Employment programs/policies created/improved

(6) reference EM06 People facilitated employment

(7) reference EM07 People trained in employment

(8) reference EM08 People active in systems advocacy about employment –

reference EM08A Self advocates active in systems advocacy about employment

reference EM08B Family members active in systems advocacy about employment

reference EM08C Others active in systems advocacy about employment

(9) reference EM09 Self-advocates, family members and others trained in systems advocacy about employment

reference EM09A Self-advocates trained in systems advocacy about employment

reference EM09B Family members trained in systems advocacy about employment

reference EM09C Others trained in systems advocacy about employment

~~(10) reference EM10 Other Performance Target~~

~~c. HOUSING (HO) - Adults choose where and with whom they live.~~

~~(1) reference HO01 Individuals have homes of their choice through Council efforts~~
~~(2) reference HO02 People moved from congregate settings to homes in the community~~
~~(3) reference HO03 Dollars leveraged for housing~~
~~(4) reference HO04 Banks made mortgage funds available to enable people to own their own homes~~
~~(5) reference HO05 Housing programs/policies created/ improved~~
~~(6) reference HO06 Units of affordable, accessible housing made available~~
~~(7) reference HO07 People facilitated home ownership/ rental~~
~~(8) reference HO08 People trained in housing~~
~~(9) reference HO09 People active in systems advocacy about housing~~
~~reference HO09A Self-advocates active in systems advocacy about housing~~
~~reference HO09B Family members active in systems advocacy about housing~~
~~reference HO09C Others active in systems advocacy about housing~~
~~(10) reference HO10 People trained in systems advocacy about housing~~
~~reference HO10A Self-advocates trained in systems advocacy about housing~~
~~reference HO10B Family members trained in systems advocacy about housing~~
~~reference HO10C Others trained in systems advocacy about housing~~
~~(11) reference HO11 Other Performance Target Description~~

d. HEALTH (HE) - People are healthy and benefit from the full range of needed health services.

(1) reference HE01 People have needed health services through Council effort
(2) reference HE02 Dollars leveraged for health services
(3) reference HE03 Health care programs/policies created/improved
(4) reference HE04 People improved health services
(5) reference HE05 People trained in health services
(6) reference HE06 People involved in systems advocacy about health
reference HE06A Self-advocates active in systems advocacy about health
reference HE06B Family members active in systems advocacy about health
reference HE06C Others active in systems advocacy about health
(7) reference HE07 Other Performance Target Description

e. ED<u></u>UCATION and EARLY INTERVENTION (ED) - Students reach their educational potential and infants and young children reach their developmental potential.

(1) reference ED01 Students have the education and support they need to reach their educational goals through Council efforts
(2) reference ED02 Infants and young children have the services/supports needed to reach developmental goals through Council efforts
(3) reference ED03 Students transitioned from school to community and jobs
(4) reference ED04 Children transitioned from early intervention

and pre-school to inclusive classrooms/schools

(5) reference ED05 Dollars leveraged for education

(6) reference ED06 Education programs/policies created/ improved

(7) reference ED07 Post-secondary institutions improved inclusive education

(8) reference ED08 Schools improved IEP practices

(9) reference ED09 People facilitated inclusive education

(10) reference ED10 People trained in inclusive education

(11) reference ED11 People active in systems advocacy about inclusive education

(12) reference ED12 Parents or guardians trained regarding their child's education rights

(13) reference ED13 Other Performance Target Description

f. CHILD CARE (CH) - Children & families benefit from a range of inclusive, flexible child care options.

(1) reference CH01 Children in inclusive child care settings through Council efforts

(2) reference CH02 Dollars leveraged for child care programs

(3) reference CH03 Child care programs/policies created/ improved

(4) reference CH04 People facilitated inclusive child care

(5) reference CH05 People trained in child care

(6) reference CH06 People active in systems advocacy about child care

reference CH06A Self-advocates active in systems advocacy about child care

reference CH06B Family members active in systems advocacy about child care

~~reference CH06C Others active in systems advocacy about child care~~

~~reference CH07 People trained in systems advocacy about child care~~

~~reference CH07A Self-advocates trained in systems advocacy about child care~~

~~reference CH07B Family members trained in systems advocacy about child care~~

~~reference CH07C Others trained in systems advocacy about child care~~

~~(8) reference CH08 Other Performance Target Description~~

~~g. RECREATION (RE) - People benefit from inclusive recreational, leisure and social activities consistent with their interests and abilities.~~

~~(1) reference RE01 People active in recreational activities through Council efforts~~

~~(2) reference RE02 Dollars leveraged for recreation programs~~

~~(3) reference RE03 Recreation programs/policies created/ improved~~

~~(4) reference RE04 People facilitated recreation~~

~~(5) reference RE05 People trained in recreation~~

~~(6) reference RE06 People active in systems advocacy about recreation~~

~~reference RE06A Self-advocates active in systems advocacy about recreation~~

~~reference RE06B Family members active in systems advocacy about recreation~~

~~reference RE06C Others active in systems advocacy about recreation~~

~~(7) reference RE07 People trained in systems advocacy about recreation~~

~~reference RE07A Self-advocates trained in systems advocacy about recreation~~

~~reference RE07B Family members trained in systems advocacy about recreation~~

~~reference RE07C Others trained in systems advocacy about recreation~~

(8) reference RE08 Other Performance Target Description

h. TRANSPORTATION (TR) - People have transportation services for work, school, medical, and personal needs.

(1) reference TR01 People have transportation services for work, school, medical, and personal needs

(2) reference TR02 Dollars leveraged for transportation programs

(3) reference TR03 Transportation programs/policies created/improved

(4) reference TR04 People facilitated transportation

(5) reference TR05 People trained in transportation

(6) reference TR06 People active in systems advocacy about transportation

reference TR06A Self-advocates active in systems advocacy about transportation

reference TR06B Family members active in systems advocacy about transportation

reference TR06C Others active in systems advocacy about transportation

(7) reference TR07 People trained in systems advocacy about transportation

reference TR07A Self-advocates trained in systems advocacy about transportation

reference TR07B Family members trained in systems advocacy about transportation

reference TR07C Others trained in systems advocacy about transportation

(8) reference TR08 Other Performance Target Description

i. FORMAL AND INFORMAL COMMUNITY SUPPORTS (CS) - Individuals have access to other services available or offered in a community, including formal and informal community supports that affect their quality of life.

~~(1) reference CS01 Individuals receive formal/informal community supports~~

~~(2) reference CS02 Dollars leveraged for formal/informal community supports~~

~~(3) reference CS03 Programs/policies created/improved formal/informal community supports~~

~~(4) reference CS04 People facilitated formal/informal community supports~~

~~(5) reference CS05 People trained in formal/informal community supports~~

~~(6) reference CS06 People active in systems advocacy about formal/informal community supports~~

~~reference CS06A Self-advocates active in systems advocacy about formal/informal community supports~~

~~reference CS06B Family members active in systems advocacy about formal/informal community supports~~

~~reference CS06C Others active in systems advocacy about formal/informal community supports~~

~~(7) reference CS07 People trained in systems advocacy about formal/informal community supports~~

~~reference CS07A Self-advocates trained in systems advocacy about formal/informal community supports~~

~~reference CS07B Family members trained in systems advocacy about formal/informal community supports~~

~~reference CS07C Others trained in systems advocacy about formal/informal community supports~~

~~(8) reference CS08 Buildings/public accommodations became accessible~~

(9) reference CS09 Other Performance Target Description

j. CROSS CUTTING (CR) - Targets that cut across all areas of emphasis.

(1) reference CR01 Public policymakers educated by Council about issues related to Council initiatives

(2) reference CR02 Copies of products distributed to policymakers about issue related to Council initiatives

(3) reference CR03 Members of the general public estimated to have been reached by Council public education, awareness and media initiatives

1200.2 For CDD funded programs, quarterly reports must be submitted to the Council office prior to each CDD quarterly meeting (5th working day of January, April, July, and October). Reports must reflect performance measures as specified in the grant and ADD Performance Reports.

1200.3 For CDD funded programs, an annual CDD Program Performance Report (PPR) must be submitted to the Council office by the last working day of October each year.

1200.4 CDD funded services viewed as Ademonstration programs@ i.e., Employment Activities, Community Living, HCBS-MR/DD Waiver, and Family/Early Intervention, must meet their specific program standards within the Minimum Standards for Community Mental Health/Mental Retardation Services, if program standards are applicable.

~~PART V~~

~~BUREAU OF MENTAL HEALTH GENERAL STANDARDS~~

SECTION A - GENERAL STANDARDS

Standards contained in this section apply to Bureau of Mental Health programs. The provider/sponsoring agency for such programs and services must meet standards in Part I - Procedures for Certification, Part II - Organization and Management, Part III - Human Services and as applicable, Part VI - Children and Youth Services; Part VII - Alcohol and Drug Services; Part VIII - Adult Community Mental Health Services; Part IX - Adult Day Center Services for Persons with Alzheimer's Disease and Other Dementia; and, Part X - Other Community Services for Individuals with Mental Illness, Mental Retardation/ Developmental Disabilities, or Substance Abuse Diagnoses.

1300.0 The written policies and procedures manual must describe the placement of individual services for which the provider is certified within the agency's organizational structure.

1300.1 Service providers must request a written consent to release information from individuals eighteen (18) years and older which will allow the provider to involve the family in the individual's treatment. Providers must request such a release of information upon admission or within a reasonable time following admission, not to exceed thirty (30) days.

1300.2 Within twenty-four (24) hours prior to the release or discharge of any civilly committed (outpatient commitment) 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 form and has provided in writing a current address and telephone number, if applicable, to the director for such purpose.

1300.3 In addition to Standard 10.8, written policies must also include:

a. Hours of operation;

b. Location(s) of services;

c. Procedures for maintaining and addressing the waiting list for admission to any services offered by the agency.

1300.4 Program rules for any Bureau of Mental Health service must be posted in a location highly visible to the individuals served in the program

and/or made readily available to those individuals, with documentation in the record indicating that availability.

1300.5 Emergency telephone numbers must be available as indicated below in each day and residential program site. Numbers must be included for:

a. Family member(s) or other contacts (if appropriate and consent is on file) located in a file available to staff;

b. Case manager(s) and therapist for individuals (if applicable) located in a file available to staff;

c. Police, posted in a conspicuous location near the phone;

d. Fire department, posted in a conspicuous location near the phone;

e. Poison control center, posted in a conspicuous location near the phone; and,

f. Ambulance/emergency medical services, posted in a conspicuous location near the phone (EMS).

1300.6 Written policies and procedures must address staff responsibilities and roles in protecting the rights of individuals served by the provider as described in Part III, Section C - Rights of Individuals Receiving Services.

1300.7 Providers must develop and maintain a plan for responding to natural and manmade disasters. This plan must include at a minimum:

a. Staff training in the handling of natural and manmade disasters;

b. Policies and procedures for responding to natural and manmade disasters or other traumatic events, including coordination of response with other local and state emergency management response or relief organizations; and

c. Assurance that staff will be available to respond to natural and manmade disasters.

Bureau of Mental Health Residential and Inpatient Chemical Dependency Unit Programs

1310.0 All residential and Inpatient Chemical Dependency Unit programs must develop written procedures for setting and collecting fees (in accordance

with Standard 30.1). Additionally, these procedures must include development of a written financial agreement with each individual or parent/legal guardian (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 guardian and provided in two (2) or more copies, one (1) copy given to the individual/parent/legal guardian, and one (1) copy placed on file in the individual's case record; and

c. Do not relieve the provider of the residential or Inpatient Chemical Dependency Unit program of the responsibility for the protection of the person and personal property of the individual admitted to the residential program for care.

1310.1 The provider must have a written plan describing how emergency medical and dental care services are provided to individuals served in the residential and Inpatient Chemical Dependency Unit program(s).

1310.2 The provider must maintain updated written documentation that individuals served in its residential and Inpatient Chemical Dependency Unit program(s) are provided with varied, well-balanced meals at least three (3) times daily, seven (7) days per week. Special diets must be provided for individuals needing special consideration when documented by a physician.

1310.3 The provider must document that each individual served in its residential and Inpatient Chemical Dependency Unit program(s) is provided with an orientation that includes, at a minimum:

a. An explanation of the program's services, activities, performance expectations, and rules and regulations;

b. An explanation and provision of a written copy of rights of individuals served by the program;

c. Familiarization of the individual with the premises;

d. An introduction to program personnel and to other individuals; and,

e. An initial schedule of the activities of the individual.

SECTION B - CASE RECORD MANAGEMENT AND RECORD KEEPING

Standards that follow include requirements pertaining to all case records for individuals receiving mental health (adults and children/youth) services, substance abuse services, and Alzheimer's and other dementia services. Providers must also meet applicable case records standards pertaining to individual service or program areas contained in Parts V through X.

1400.0 The Face Sheet/Identification Data Form must consist of data items specified in the Core Client Data Set in the current Mississippi Department of Mental Health Manual of Uniform Data Standards and any ancillary data as required by the Department of Mental Health. The Face Sheet must be in the record of the individual receiving services and must be completed within time lines specified for intake/assessment for new or readmissions, as indicated in the sections that follow and/or in the current Bureau of Mental Health Record Guide. The face sheet must be updated as needed and reviewed at least annually as a part of the review/rewriting of the Comprehensive Treatment Plan.

1400.1 All case records of individuals served by the program must contain documentation of information specified in Standard 200.5. Additional information must be included for certain services as follows:

a. For individuals entering mental health case management services, the Case Management Life Domains Assessment/Service Plan;

b. For individuals receiving alcohol and drug abuse services:

(1) Assessment/Educational Activities Documentation Form;

(2) Needs Assessment/Aftercare Plan;

(3) Documentation of detoxification monitoring for primary residential programs;

(4) Documentation of vocational, educational, employment, or related activities for transitional residential program.

c. For persons served in any residential program:

(1) Residential Visitation/Telephone Agreement (if applicable);
(2) Medical Screening Report (as required in Standard 73.8).

d. For children or adults, copies of any current court orders pertaining to outpatient mental health treatment.

e. For youth served in therapeutic group homes and therapeutic foster care programs:

(1) Documentation that information required in Standard 1611.0 has been explained/provided in writing to the parent(s), legal guardian(s), and youth prior to or upon admission to the program;

(2) Results of dental examination required in 1410.0;

(3) Current photograph of the youth;

(4) Educational records and reports (See also 1600.1);

(5) Copies of any current court order pertaining to the treatment or custody of the youth;

(6) Any permission forms signed by the parent(s)/legal guardian(s) for the youth to participate in specific program activities;

(7) Permission form(s) for staff to provide first aid.

f. For youth served in any mental health programs:

(1) Any consent forms obtained for requesting records from other agencies (such as schools, Department of Human Services, etc.);

(2) Documentation that parents/legal guardians received information on rights/procedures for seeking an evaluation for special education procedures, if applicable;

(3) Documentation of referrals/follow-up contacts for youth found ineligible for services, if applicable.

1400.2 An Intake/Assessment must be initiated on the first day of service and completed by date(s) indicated below and must include the signature and credentials of the staff conducting the assessment, and be maintained in the case record of the individual receiving services:

a. Within thirty (30) days from the date of admission for outpatient and support services (to include all psychosocial rehabilitation, all clubhouse, all day treatment, all individual/group/family therapy, all family support/education services, all day support, all case management, all mental illness management, all individual therapeutic support, all school-based services, all alcohol/drug outreach/aftercare, and all alcohol/drug abuse outpatient services,);

b. Within seven (7) days from the date of admission for:

(1) All residential treatment services to include any program for alcohol/drug abuse, children/youth, and adults;

(2) Chemical dependency unit programs;

(3) Day Programs for persons with Alzheimer's and other dementia.

c. Within twenty-four (24) hours of admission for any crisis or emergency services.

d. Within twenty-four (24) hours of admission for partial hospitalization.

e. Within twenty-four (24) hours of admission for respite services.

1400.3 The Intake/Assessment process must be sufficient to document the need for services to be provided and the diagnostic categories assigned. The Intake/ Assessment must contain at a minimum the following information, defined further in the current Bureau of Mental Health Record Guide (not applicable for Alzheimer's programs):

a. Description of the presenting problem;

b. Social history, including family background;

c. Educational/vocational history;

d. Mental health history, including history of previous treatment;

e. Current medications;

f. Medical history;

g. Substance abuse/use history;

h. Community support;

i. Source of referral;

j. Mental status;

k. Evaluation summary;

l. Diagnostic impression;

m. Recommendations for treatment;

n. Addendum requirements for Children and Youth (as noted in the current Bureau of Mental Health Record Guide);

o. Addendum requirement for Substance Abuse (as noted in the current Bureau of Mental Health Record Guide).

1400.4 A licensed physician (required for all persons receiving Medicaid services), with psychiatric training or documented competency in the use of the DSM diagnostic criteria by experience or training, or a licensed psychologist must certify that services are medically/therapeutically necessary as follows for individuals receiving services from funds made available by the Department of Mental Health, as follows: (This standard is not applicable for programs for individuals with Alzheimer's Disease/other dementia.)

a. Adults with a serious mental illness (SMI) and children and youth with serious emotional disturbance (SED) must be seen and evaluated by a licensed physician or licensed psychologist as a part of the admission process to certify that the services planned are medically/therapeutically necessary for the treatment of the individual. A physician or a licensed psychologist must then physically visit and evaluate the status of the individual every six months thereafter and recertify that the services being provided remain medically/therapeutically necessary.

b. Individuals , who do not meet the eligibility categories of adults with SMI or children with SED, but who remain in treatment one hundred twenty (120) days or more must be seen and evaluated by a licensed physician or licensed psychologist to certify that services planned and being provided are therapeutically necessary. A licensed physician or licensed psychologist must then recertify every six months after the date of the initial certification that services being provided remain medically/therapeutically necessary.

c. Certification and recertification (in a. and b. above) must be documented as part of the Comprehensive Treatment Plan; and,

d. For individuals receiving Individual Therapeutic Support or Acute Partial Hospitalization, the individual case record must contain a physician's order for the service stating that inpatient care would be necessary without the specific service.

1400.5 An individualized Comprehensive Treatment Plan based on the strengths and needs identified in the Intake/Assessment and other assessments must be developed after each admission and readmission to the program. The Comprehensive Treatment Plan must be developed within the following time lines:

a. Within thirty (30) days of the date of admission/re-admission for outpatient or support services (to include all psychosocial rehabilitation, all clubhouse, all day treatment, all individual/group/ family therapy, all family support/education services, all day support, all case management, all mental illness management, all individual therapeutic support, all school-based services, all alcohol/drug outreach/aftercare, all alcohol/drug outpatient services), then updated as needed but at least annually thereafter;

b. Within fifteen (15) days of the date of completion of Intake/ Assessment for all residential services (except as outlined below), then updated as needed but not less often than annually thereafter;

c. Within seven (7) days of the date of completion of the Intake/ Assessment for Respite Care and Residential Crisis Intervention Services and then updated as needed but not less often than every thirty (30) days thereafter;

d. Within seven (7) days of the date of admission/re-admission for all alcohol/drug residential services and Chemical Dependency Unit services and then updated as needed but not less often than annually thereafter;

e. Within seventy-two (72) hours of the completion of Intake/ Assessment for Emergency/Crisis Services and for Partial Hospitalization Services, then updated as needed but not less often than thirty (30) days thereafter;

f. For all Alcohol/Drug Abuse Treatment Programs, the Needs Assessment/Aftercare Plan must be developed and on file at least seven (7) days prior to transfer or discharge from treatment.

1400.6 The Comprehensive Treatment plan must (not applicable for Alzheimer's programs):

a. Include an individualized statement of the problem(s), strength(s), and diagnosis of the individual;

b. Include measurable, individualized objectives of treatment with program activities designed to address those objectives;

c. Identify the services to be provided;

d. Be developed with the individual and/or parent/legal guardian and be signed by the individual and staff responsible;

e. Be updated as needed to accurately reflect current circumstances and functioning level. Addenda/changes must be clearly identified, and must be signed by staff and the individual being served as required by standards and reimbursement sources. Addenda to the original plan must be made on the Comprehensive Treatment Plan Form.

f. Be reviewed every:

(1) Six (6) months for children and youth outpatient services.

(2) Thirty (30) days for children and youth residential and day treatment services.

g. For alcohol and drug abuse services, the Comprehensive Treatment Plan must be staffed/reviewed as needed but no less than every:

(1) Fifteen (15) days after the initial staffing for all Residential Services and Chemical Dependency Unit Services;

(2) Thirty (30) days after the initial staffing for Intensive Outpatient and DUI Outpatient Treatment Tracks;

(3) Ninety (90) days after the initial staffing for general outpatient and Aftercare services.

1400.7 A functional assessment, approved by the Department of Mental Health, must be completed for each individual as follows (not applicable for Alzheimer's programs):

a. For individuals admitted to outpatient mental health services for adults, a functional assessment must be conducted between thirty (30) days and sixty (60) days after Intake/Assessment and at least every twelve (12) months thereafter.

b. For individuals admitted to primary alcohol and drug treatment services (which include general outpatient services, DUI treatment services, and primary residential treatment programs), functional assessments and/or other performance measures must be implemented and data submitted as required by the Division of Alcohol and Drug Abuse;

c. For children and youth admitted to mental health services who have 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 guardian 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 Intake/Assessment process and/or of the next occurring Comprehensive Treatment Plan review.

1400.8 Therapeutic activities provided on behalf of the individual receiving services must be documented in individualized Progress Notes, which at a minimum:

a. Include the following elements:

(1) A summary of the therapeutic activities of each contact;

(2) An assessment of the progress made toward goals and objectives of the Comprehensive Treatment Plan, Aftercare Plan and/or Plan for Care for Alzheimer's Day Programs.

(3) A statement of immediate plans for future therapeutic activities.

b. Identify the date, type of service being rendered, and the length of time spent in providing the service.

1400.9 Specific time line requirements for Progress Notes are as follows:

a. At least monthly for Psychosocial Rehabilitation/Clubhouse Services, Elderly Psychosocial Rehabilitation, Day Support (adult services), and Aftercare Services (Alcohol and Drug Abuse);

b. At least weekly for all Residential Services (not including Crisis Residential, Intensive Residential, Alcohol and Drug Abuse Residential, or Respite). Note: Residential Services Progress Notes must summarize other required Progress Notes, as well as shift records (logs) from the residential setting;

c. At least weekly group Progress Notes for Alcohol and Drug Abuse Primary and Transitional Residential Services, Chemical Dependency Unit Services and Intensive Outpatient Services. These weekly group notes must summarize the group therapy sessions from the week of service;

d. At least a weekly summary Progress Note for Children's Day Treatment. (Notes must be based on daily contact recordings);

e. At least weekly for Alzheimer's Day Center programs;

f. At least daily for Acute Partial Hospitalization or Intensive Residential Treatment Services, Crisis Residential Services, or Respite Care;

g. For each contact for outpatient therapy, including Individual, Group or Family Therapy and DUI Outpatient Treatment Tracks and in Alcohol and Drug Abuse Residential Services, Chemical Dependency Unit Services and Aftercare Services for each Individual or Family Therapy session;

h. For each contact for any Emergency Service, Intensive Crisis Intervention, Case Management, Prevention/Early Intervention Service (Children & Youth), School-Based Services (Consultation and Crisis Intervention), Mental Illness Management, and Individual Therapeutic Support.

1401.0 For individuals entering mental health case management, the provider must maintain documentation of a Case Management Life Domain Assessment/ Service Plan. This plan must:

a. Be developed within thirty (30) days after admission to case management services;

b. Identify the strengths, needs, and personal goals of the individual, as well as the case management activities to be provided;

c. Identify the case management activities to be provided. For all case management services (case management, school-based services, mental illness management services, and individual therapeutic support), clear documentation that the case management services provided are related to the Case Management Life Domain Assessment/Service Plan, as well as the Comprehensive Treatment Plan;

d. Be developed initially and rewritten at least every twelve (12) months with the individual and, as appropriate, for children and youth with the parent/guardian, the school system, and the Department of Human Services; and,

e. Be reviewed every six months for children and youth.

1401.1 Individual records must be closed when there has been no contact for a twelve (12) month period. For alcohol and drug services records, when no contacts are recorded for ninety (90) days, the case must be staffed and a contact attempt must be made and documented. If the individual does not resume treatment, the case must be closed at the following ninety (90) day staffing.

Mental Health Services for Children and Youth

1410.0 Arrangements must be made for and documentation maintained in the record for children/youth in therapeutic group homes and therapeutic foster care to have a dental examination within sixty (60) days after

admission, unless there is evidence that the child/youth has had an examination within the past twelve (12) months.

1410.1 Documentation must be maintained for children/youth in a group home or therapeutic foster care indicating the progress/results of a weekly (minimum) face-to-face contact with their mental health therapist.

1410.2 Documentation must be maintained in the case record for children/youth in Crisis Intervention Services indicating the progress/results of the therapy session(s) that must take place during the first fourteen (14) days after admission.

1410.3 Discharge plans for children and youth from therapeutic group homes, therapeutic foster care, and crisis intervention must:

a. Document that, in the case of youth in Mississippi Department of Human Services' custody, the social worker from the county of residence of the individual is provided the opportunity to be involved in the discharge/placement plans and there is an opportunity for one pre-placement visit prior to discharge;

b. Document that the discharge plan has been developed in consultation with the parent(s) and/or other legal custodian;

c. Document that an appointment has been scheduled with the CMHC responsible for services in the county where the youth will reside upon discharge.

Alcohol and Drug Services

1420.0 The Assessment/Educational Activities Documentation form must be completed for all individuals receiving substance abuse services (except for prevention-only programs) according to the following schedule:

a. All individuals receiving substance abuse treatment services must receive the TB and HIV/AIDS Risks Assessment at the time of the Intake/Assessment (See 1400.2) 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 that both risk assessments were administered, with documentation of

~~follow-up of results if applicable, in a primary treatment program completed within the last thirty (30) days.~~

~~(2) For Outreach/Aftercare Services - The Assessment/ Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that both risk assessments were administered with documentation of follow-up and results if applicable) during substance abuse treatment program completed within the last thirty (30) days.~~

~~b. All individuals receiving substance abuse treatment services must receive the educational information concerning HIV/AIDS, Sexually Transmitted Diseases, Tuberculosis, and the Mississippi Implied Consent Law as part of treatment either in an individual or group session according to the following schedule:~~

~~(1) Prior to completion of treatment for:~~

~~(a) Primary Residential Services;~~

~~(b) Transitional Residential Services unless the Assessment/Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that the information was provided during primary treatment;~~

~~(c) Chemical Dependency Unit Services;~~

~~(d) Intensive Outpatient Services;~~

~~(e) Specific DUI Outpatient Treatment Tracks.~~

~~(2) Within ninety (90) days of the date of admission for:~~

~~(a) General Outpatient Services;~~

~~(b) Outreach/Aftercare Services unless the Assessment/ Educational Activities Documentation Form (or a copy) is in the individual's case record verifying that the information was provided during substance abuse treatment.~~

1420.1 In addition to the Intake/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:

(1) Previous DUI's; and,

(2) Moving violations.

b. The results and interpretations of the Mortimer Filkins, SASSI, or other DMH approved diagnostic instrument. The approval must be obtained in writing.

1420.2 Providers of detoxification services must maintain documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the detox program and every two (2) hours during the second twenty-four (24) hours, and as needed thereafter, when prescribed by a physician.

1420.3 Providers of Transitional Residential Services must provide in the case records weekly documentation which addresses employment, vocational training, and/or academic activities.

1420.4 Providers of Aftercare Services must document in the case record at least one attempted contact per month, unless group, family or individual contact is documented during that month.

Mental Health Services for Adults

1430.0 Case records of individuals receiving Elderly Psychosocial Rehabilitation services must include documentation in the case record of the following:

a. A medical screening conducted within thirty (30) days prior to admission and at least once a year thereafter;

b. A nursing plan signed by a registered nurse, with medical monitoring by a registered nurse, at a minimum, once during each six-month period.

~~PART VI~~

~~COMMUNITY MENTAL HEALTH SERVICES FOR CHILDREN AND YOUTH~~

SECTION A - GENERAL STANDARDS

Standards contained in this section apply to mental health services for children/adolescents certified by the Bureau of Mental Health/Division of Children and Youth Services. The providers of such services must meet standards in Part I Procedures for Certification, Part II Organization and Management, Part III Human Services, and Part V Bureau of Mental Health General Standards, Part VI Children and Youth Services, and applicable sections of Part X Other Community Services for Individuals with Mental Illness, Mental Retardation/Developmental Disabilities and Substance Abuse. Providers/sponsoring agencies seeking to provide Acute Partial Hospitalization Services for children with serious emotional disturbance must also meet standards in Part VIII Adult Community Mental Health Services, Section K Acute Partial Hospitalization Services. Providers required by state statute to provide Pre-Evaluation Screening and Civil Commitment Examinations (for children over 14 years of age) must comply with standards in Part VIII Adult Community Mental Health Services, Section F Pre-Evaluation Screening and Civil Commitment Examination Services.

1500.0 The written policy and procedure manual must describe the placement of individual services for which the provider is certified within the agency's organizational structure.

1500.1 Written policies and procedures must address admission to services and must at a minimum:

a. Describe the process for admission or readmission to service(s);

b. Define the criteria for admission or readmission to service(s), including:

(1) Description of the population to be served (age(s), eligibility criteria, any special populations, etc.);

(2) Process for determination of eligibility for children's service(s) offered by the provider.

c. Describe the process or requirements for collecting intake/assessment information, including the process for requesting appropriate consent to obtain relevant records from other agencies (such as schools, Department of Human Services or other child/family service agencies/providers).

d. Describe written materials provided to children/youth and parent(s)/legal guardian(s) upon admission, including materials that may be included in an orientation packet, etc.

e. Describes the process for informing youth (if age-appropriate) and youth's parent(s)/legal guardian(s) of their rights and responsibilities (including any applicable program rules for residential programs) prior to or at the time of admission.

f. Describe the process for informing parent(s)/legal guardian(s) of their rights and the procedure(s) for seeking an evaluation under the Individuals with Disabilities Act (IDEA), when a child/youth is found to be in need of referral to the local school district for evaluation for special education services. Receipt of this information by the youth's parent(s)/legal guardian(s) must be documented.

g. Describe the process to be followed when a child/youth is found ineligible for admission or readmission to service(s) offered by the provider, including referral to other agencies and follow-up, as appropriate. Such referral(s) and follow-up contacts must be documented.

h. Describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available to children/youth by the provider.

1500.2 All of the following information must be documented to support an eligibility determination of serious emotional disturbance:

a.. Youth has at least one of the eligible diagnosable mental disorders defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or subsequent editions.

b. Youth with serious emotional disturbance are ages birth up to 21 years.

c. 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 Department of Mental Health.

1500.3* Community mental health centers (providers certified under the DMH-C option) must employ an individual to supervise children's mental health services on a full-time basis, i.e., with administrative authority and responsibility for children's mental health services after the effective date

~~of these standards. (See Part II, Section B - Personnel, 20.7 for minimum qualifications.)~~

PART XV

CHILDREN/YOUTH MENTAL HEALTH SERVICES

All sections contained in this part pertain specifically to services and supports that are available to children/youth with serious emotional disturbance.

XV.C.3.

~~1500.4 All providers certified as community mental health centers (DMH-C) must make available or participate in at least one Making a Plan (MAP) Team in each community mental health region. MAP Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders, including, but not limited to, conduct disorders, or mental illness, who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement. Each MAP Team must be comprised of, at least, one child behavioral health representative employed by the Regional CMHC with a Bachelor's degree meeting Minimum Standard 20.5 f., at a minimum. Additionally there must be one representative, at a minimum, from each of the following:~~

~~a. Each local school district in a county;~~

~~b. County Family and Children's Services Division of the State Department of Human Services;~~

~~c. County or Regional Youth Services Division of the State Department of Human Services; and,~~

~~d. County or Regional Office of the State Department of Rehabilitation Services.~~

~~Three additional members may be added to each team, one of which may be a representative of a family education/support 501(c)3 organization with statewide recognition and specifically established for the population of children addressed by the MAP Team (described above). The remaining two members will be representatives of significant community-level stakeholders with resources that can benefit the children with serious emotional disturbance.~~

~~1500.5 The community mental health center (DMH-C) must maintain a current written agreement from agencies participating in the MAP team that identifies the primary functions of the team, including, at a minimum, the following functions:~~

~~a. Review of cases of children/youth, ages up to 21 years, when appropriate, who have a serious emotional disturbance and who are at risk for inappropriate out-of-home placement due to lack of access to or availability of needed services in the home and community.~~

~~b. Identification of community-based services that may divert children/youth (described in a.) from out-of-home placement.~~

~~c. Facilitation of the provision and coordination of services across agencies/entities for the target population (described in a.).~~

~~d. Facilitation of continuity of care for children/adolescents with serious emotional disturbance; and,~~

~~e. Facilitation of support for children/youth with serious emotional disturbances and their families.~~

IV.E.7. ~~1500.6~~ Providers of school-based mental health services 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:

a. Describes in detail the respective responsibility(ies) of each entity in the provision of school-based mental health services and any support services necessary for the provision of that service (such as facilities, staffing, transportation, etc.);

b. Includes a written acknowledgment of the school district's receipt and understanding of standards applicable to the children's mental health standards.

~~1500.7 All providers must have an overall schedule available to children and their families for each service for which they are certified, which includes, at a minimum:~~

~~a. Hours of daily operation/hours service is available;~~

b. Number of days per year the service will be provided/be available; and,

c. Scheduled dates of closure/unavailability and reasons.

1500.8* Emergency telephone numbers must be posted in a conspicuous location near each telephone in each day and residential program site. Numbers must be included for:

a. Parent(s) or legal guardian(s) for individual youth;

b. Case manager(s) and therapist for individual youth;

c. Police;

d. Fire department;

e. Poison control center; and,

f. Ambulance/emergency medical services (EMS).

1500.9* Written policies and procedures must address all staff's responsibilities and roles in protecting the rights of youth/family served by the provider as described in Part III, Section C - Rights of Individuals Receiving Services. These rights must include, but not be limited to the right not to be subjected to corporal punishment or unethical treatment. Examples of prohibited punishments, in addition to those described under Part III, Section C - Rights of Individuals Receiving Services, include:

a. Any type of physical hitting or any type of physical punishment inflicted in any manner upon the body;

b. Physical exercises such as running laps or performing push-ups, when used solely as a means of punishment;

c. Requiring or forcing the child/youth to take an uncomfortable position such as squatting or bending, or requiring or forcing the child/youth to repeat physical movements when used solely as a means of punishment;

d. Punishment which subjects the child/youth to verbal abuse, ridicule, or humiliation;

e. Excessive denial of on-site program services or denial of any essential program service solely for disciplinary reasons;

~~f. Withholding of any meal;~~

~~g. Requiring the child/youth to remain silent for long periods of time;~~

~~h. Extensive withholding of emotional response or stimulation.~~

~~The following are prohibited in residential programs:~~

~~i. Exclusion of the child/youth from entry to the residence;~~

~~j. Denial of visiting or communication privileges with family as a means of punishment;~~

~~k. Denial of shelter, clothing, or bedding;~~

~~l. Denial of sufficient sleep;~~

~~m. Assignment of unduly physically strenuous or harsh work;~~

~~1501.0 Training which addresses rights of individuals served by the program (Standard 50.2 e.) conducted and documented for newly hired and existing staff and volunteers in programs serving children must include information specific to prohibited punishments and unethical treatment as described in Part III, Section C – Rights of Individuals Receiving Services and as described in this section.~~

IV.E.1. ~~1501.1~~ Program activities must be designed to address objectives in individualized treatment plan. Treatment plan objectives must reflect individual strengths and needs of individual children/adolescents and/or families/guardians served by the program as reflected by intake/assessments and/or progress notes.

~~1501.2 Individualized treatment plans must address and/or be revised to address strengths and needs of the child/youth. Behavioral deficits/excesses identified in the intake/assessment and/or through observation of the youth in the program must be documented. The individualized treatment plan must address and/or be revised to address behavior problems of a serious nature and behavior problems that are documented for a sufficient period of time.~~

~~SECTION B - RESIDENTIAL SERVICES~~

~~Therapeutic Group Homes and Therapeutic Foster Care~~

~~1600.0 In addition to components described in General Standards for Children and Youth Services, the written policy and procedure manual for the operation of residential service(s) must also include a description of procedures for determining the need for and development, implementation and supervision of behavior change/management programs.~~

XI.C.1. ~~1600.1~~ Each child/youth 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/ adolescent and is accredited by the Mississippi Department of Education.

Therapeutic Group Homes (TGH)

XI.I.7. The primary mission of therapeutic group homes is to provide individualized services to youth with serious emotional disturbances in a structured, therapeutic home environment. Youth served in therapeutic group homes are individuals who need intensive treatment in a community-based residential setting; however, they do not need services provided in a long-term psychiatric residential treatment center or in an inpatient (acute) hospital setting. Program emphasis in a therapeutic group home is on developing or increasing social and independent living skills youth need to make a successful transition to a less restrictive living situation. Therapeutic group homes typically include an array of therapeutic interventions, such as individual, group and/or family therapy and individualized behavior management programs.

~~1610.0 Each therapeutic group home must be a single home located in a residential area and must provide a homelike atmosphere.~~

XI.I.10 ~~1610.1~~ The ~~residential~~ TGH facility must be equipped with an operable electronic security system that has the capacity to monitor unauthorized entrance, egress, or movement through the facility.

~~1610.2 The policy and procedures manual for the program must include procedures for conducting searches of the person(s), room(s) and/or personal possessions of individuals served in the residential program, including typical reasons for such searches, designation of program staff who can authorize such searches, and documentation of such searches in individual case records.~~

~~1610.3 Whenever there is a reason to believe that the security of a residential facility or the health or safety of anyone is endangered, a search of each child's/youth's person, room, locker, or possessions can be~~

~~conducted if authorized by the residential program director or designee, as defined in program policies and procedures. The reason for the search must be documented and maintained in the record of each child/youth whose person, room, locker or possessions were searched.~~

XI.I.9. ~~1610.4~~ The maximum bed capacity of each TGH ~~therapeutic group home must not exceed the current maximum capacity for each home certified by the Department of Mental Health, which will be for no more than~~ is ten (10) beds per home for youth twelve (12) years of age and over and ~~no more than~~ eight (8) beds for youth under 12 years of age. The Mississippi ~~Department of Mental Health~~ DMH may require a lower bed capacity than described in this standard, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of youth served by the individual home.

~~1610.5 The staffing plan for therapeutic group homes, including credentials of staff to be employed and shift/duty assignments, must be submitted to the Mississippi Department of Mental Health (as part of the application for certification) and approved prior to youth being admitted to the home.~~

XI.I.11. ~~1610.6~~ The provider must ensure that the staff on-site are of a sufficient number to provide adequate supervision of youth in a safe, therapeutic home environment and must meet the following minimum requirements:

~~a. At least one staff member (which can be a direct care worker or house parent) must be assigned to direct service responsibilities for every five youth during all hours.~~

a. 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 every five (5) children or youth during all hours;

b. 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;

c. A full-time director (see requirement Standard VI.C.1) who is on-site at least forty (40) hours per week;

~~b. At least two staff must be assigned to direct service responsibilities during all hours youth are awake and not in school. One of the two 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.~~

~~c. Other appropriate professional staff must be available to assist in emergencies, at least on an on-call basis, at all times.~~

~~d.~~ e. The Mississippi Department of Mental Health may require a staff to youth ratio higher than described above, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of youth served by the individual home.

~~1610.7 The provider must ensure that direct care or house parent staff providing on-site direct services as described in 1610.6 meet the following minimum qualifications:~~

~~a. A high school or equivalent diploma; and,~~

~~b. At least one year of experience in working with youth.~~

~~1610.8 The provider must ensure that an adequate number of professional staff are available and on-site and are qualified by training and experience to provide programmatic direction and supervision. The staffing composition pattern will be subject to approval by the Department of Mental Health, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of youth served by individual homes. The staffing composition of all therapeutic group homes must include, at a minimum, the following:~~

~~a. A full-time director who is on-site at least 40 hours per week, and who meets the following minimum qualifications:~~

~~(1) Master's degree in the behavioral sciences or a mental health field; and,~~

~~(2) At least one year of documented experience and/or training necessary to manage and supervise residential programs for children/youth with serious behavioral/emotional disorders.~~

b. Availability of a licensed psychiatrist with experience working with children/adolescents, on an employment or contractual basis;

c. Availability of a mental health therapist or counselor who meets the following minimum qualifications:;

(1) Master's degree in mental health or related field and other qualifications as required by funding source(s) and

(2) Documented experience of at least one year or training in therapeutic intervention/treatment of children with serious behavioral/emotional disorders.

d. Availability of an additional mental health professional staff person, with at least a Bachelor's degree in a mental health or related field, if needed to meet staffing requirements described in Standard 1610.6.

1610.9 If outpatient mental health therapy and/or psychiatric services are obtained on a contractual basis from a community mental health center (DMH-C) or other provider agency, there must be in place a current, written interagency agreement between the provider of the therapeutic group home program and the provider of the outpatient mental health therapy and/or psychiatric services that addresses, at a minimum, the following:

a. Availability of a mental health therapist and/or psychiatrist who meets minimum qualifications as set forth in Standard 1610.8; and,

b. Procedures for obtaining necessary informed consent, including consent for release and sharing of information from the mental health therapist/psychiatrist and the provider of the therapeutic group home service.

1611.0 The provider must document that the following information has been provided in writing and explained in a manner easily understood to parent(s), legal guardian(s) and youth being served in the program, as part of information provided to youth, parent(s)/legal guardians prior to or upon admission to the therapeutic group home program:

a. Program rules, including those regarding visitation and consequences of noncompliance with rules; goals and critical

components of the treatment program; and expectations regarding participation in the program by parent(s)/legal guardian(s);

b. Policies and procedures concerning dating;

c. Information regarding out-of-facility activities;

d. Information concerning the school/educational services to be provided for the child/youth while he/she is in the group home; and,

e. Review of visitors, callers, relatives, or others who are identified as required "no contact" with the child/youth.

1611.1 The provider must ensure that each child/youth served in therapeutic group home program(s) has clean, comfortable, well-fitting clothes and shoes.

1611.2 All therapeutic group home programs for children/adolescents must provide a balance of age-appropriate, goal-oriented activities to meet the individualized needs and build on the strengths of children/youth served in the program. Areas to be addressed by such programs may include:

a. Social skills development;

b. Anger management;

c. Wellness education;

d. Increasing self-esteem;

e. Leisure activities;

f. Substance abuse education/counseling; and,

g. HIV education and/or counseling.

1611.3 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.

~~1611.4 Children/youth in the therapeutic group home program must receive mental health therapy services sufficient to meet their needs but, at a minimum, at least once per week.~~

~~1611.5 The provider must maintain updated daily and weekly schedule(s) of activities that reflect group activities and routines, as well as individually planned activities for the children/youth served in the home. Daily and weekly schedule(s) of activities must be maintained on file for at least three months. Group activities must be related to implementation of objectives in individualized treatment plans of youth served in the home.~~

~~Therapeutic Foster Care Programs~~

XI.G.9. Therapeutic foster care is an intensive community-based program composed of mental health professional staff and trained foster parents who provide a therapeutic program for children and adolescents with serious emotional disturbances living in a foster home.

~~1620.0 Each therapeutic foster home must have no more than one child/youth with serious emotional disturbance placed in the home at a given time.~~

XI.G.12. ~~1620.1~~ Each ~~therapeutic foster care~~ TFC program certified for ten (10) or more homes must have a full-time director~~/coordinator~~ with overall administrative and supervisory responsibility for the program. If the therapeutic foster care program is certified for less than ten (10) homes, the director~~/coordinator~~ can have administrative or supervisory responsibility for other programs; however, documentation must be maintained that at least 50% of the director's~~/coordinator's~~ time is spent in administration and supervision of the therapeutic foster care program.

XI.G.13. ~~1620.2~~ Each ~~therapeutic foster care~~ TFC program certified for ten (10) or more homes must have one full-time ~~therapeutic foster care~~ TFC specialist whose services target the ~~therapeutic foster care~~ TFC families. The ~~therapeutic foster care~~ TFC specialist's specific responsibilities must include at least the following:

a. Recruitment and training of therapeutic foster parents;

b. Conducting interviews and other necessary work to appropriately place individual youth with prospective therapeutic foster parents;

c. Maintenance of regular contact with ~~therapeutic foster care~~ TFC families and provide documentation of those contacts in the case records; and,

d. Performance of other family support activities, as needed.

XI.G.14. ~~1620.3~~ If the ~~therapeutic foster care~~ TFC program is certified for less than ten (10) homes, the ~~therapeutic foster care~~ TFC specialist can have other responsibilities; however, documentation must be maintained that at least 10% of his/her time for every one (1) therapeutic foster home is spent in performing duties of the therapeutic foster care specialist/case manager. (For example, in a program with two (2) therapeutic foster homes, at least 20% of the assigned staff's time must be spent in performing duties of the ~~therapeutic foster case~~ TFC specialist.)

~~1620.4 Therapeutic foster care programs must provide or secure mental health therapeutic services for all children/youth in the program. These services may include individual, group and/or family therapy.~~

~~1620.5 Therapeutic foster care programs must provide and/or make available services of a therapeutic foster care specialist to all foster families served in the program.~~

~~1620.6 Each therapeutic foster care program must employ or contract for the services of a psychiatrist who, at a minimum:~~

~~a. Has experience in treating children and adolescents; and,~~

~~b. Holds current licensure as a psychiatrist in the State of Mississippi.~~

~~1620.7 Each therapeutic foster care program must utilize adults with current documentation of foster parent approval by the Mississippi Department of Human Services.~~

~~1620.8 Licensed foster parents who have been recruited to work with children/youth with serious emotional disturbance in the therapeutic foster care program must successfully complete a minimum of twenty (20) hours of pre-placement training (before a child is placed with them), which addresses, at a minimum, the following topics:~~

~~a. Description of the needs of children/adolescents served in therapeutic foster care;~~

b. Role and expectation of foster parents in a therapeutic foster care program, in relation to the child/adolescent, the school, and other providers of services to the child and family; and,

c. Introduction to strategies for working with the child/adolescent in the home.

1620.9 Licensed foster parents who have been recruited to work with children/youth with serious emotional disturbance in a therapeutic foster care program must also complete the following training requirements:

a. Requirements for direct services volunteers to be completed before assignment to work with youth, as described in Standard 50.2; and,

b. Requirements for training to be completed within 30 days of child's placement in a home, as described in Standard 50.3.

1621.0 Development and revision of treatment plans for youth served in therapeutic foster care programs must reflect the input of the team of parent(s)/ guardian(s) and staff working with the youth/child.

a. The therapeutic foster care program director/coordinator, a member of the clinical staff of the therapeutic foster care program, the therapeutic foster parent(s), the child/adolescent (as developmentally appropriate) must meet to review the Comprehensive Treatment Plan and subsequent revisions.

b. Attempt(s) must be made and documented as part of treatment plan development/revision to include the birth parent(s), as appropriate, legal guardian(s), or agency representative(s) (such as the Mississippi Department of Human Services) in the meeting to review the Comprehensive Treatment Plan, to facilitate any placement transitions for the child/adolescent and family.

c. The treatment plan and subsequent revisions must also reflect input from and be approved by the psychiatrist providing services to the therapeutic foster care program.

1621.1 All therapeutic foster care program contacts of the therapeutic foster care specialist with the therapeutic foster care parent(s) must be documented in the individual case record of the parent(s).

~~1621.2 All therapeutic foster care program contacts of the mental health therapist with the child/adolescent must be documented in the individual case record.~~

XI.G.22.

~~1621.3~~ The mental health therapist must have ~~face-to-face contact with~~ at least one individual therapy session per week with ~~each~~ the child/youth ~~child/adolescent in the therapeutic foster care program at least once per week~~. ~~Two of these visits per month must occur in the therapeutic foster home.~~

At least one family session per month is required with the foster parent(s).

1621.4 The therapeutic foster care specialist must have face-to-face contact with each therapeutic foster care parent(s) at least two (2) times per month, with at least one (1) of the two contacts made during a home visit.

~~1621.5 The director/coordinator of the therapeutic foster care program must meet the following minimum qualifications:~~

~~a. A Master's degree in a mental health or related field; and,~~

~~b. At least one (1) year of experience in administration or supervision of a mental health or mental health-related program/service.~~

~~1621.6 The therapeutic foster care specialist in the therapeutic foster care program must meet the following minimum qualifications:~~

~~a. A bachelor's degree in a mental health or related field;~~

~~b. At least one (1) year of documented experience and/or training in working with children with special behavioral/emotional needs and their families/other care givers;~~

~~1621.7 The mental health therapist in the therapeutic foster care program must meet the following minimum qualifications:~~

~~a. A Master's degree in a mental health or related field and other qualifications as required by funding source(s),~~

~~b. At least one (1) year of experience and/or training in working directly with children/youth with behavioral/emotional disturbance.~~

SECTION ~~C~~ A- PREVENTION/EARLY INTERVENTION SERVICES

XV.A.1. 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 may be designed to target a specific group of children and/or their families, such as children who have been abused or neglected, teenage parents and their children, and young children and their parents. Children 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.

XV.A.2. The expected outcomes for Prevention/Early Intervention Services include:

e. Children and their families will have none or decreased involvement with the court system.
f. Children/youth with SED will have an increase in the stability of family and home placements.
g. At-risk children will receive crisis response that is timely and appropriate.

XV.A.3. ~~1700.0~~ A staff member must be designated to plan, coordinate and evaluate the prevention/early intervention program.

XV.A.4. ~~1700.1~~ All prevention/early intervention programs must maintain documentation that services include, but are not limited to, the following:

a. Utilization of a range of strategies, such as:

(1) Information activities designed to provide accurate and current information about emotional disturbance and mental illness in children and adolescents; or

(2) Affective 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.

XV.A.5. ~~1700.2~~ Prevention programs must maintain records documenting utilization of strategies as described in ~~1700.1.~~ Standard XV.A.4.

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 in accordance with the ~~Part V, Bureau of Mental Health General Standards, Section B pertaining to Case Records Management.~~ Part IV, Section H and 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.

~~SECTION D - EMERGENCY SERVICES~~

~~Emergency Services are time-limited interventions, available twenty-four (24) hours a day, seven (7) days a week. When needed, trained emergency/crisis response staff triage referrals and respond in a timely and adequate manner to diffuse the current crisis and maintain the child/youth in the least restrictive, yet appropriate environment.~~

~~Children/youth appropriate for emergency services typically are experiencing severe, demonstrable emotional/behavioral symptoms and have need requiring rapid action, in the judgement of a mental health professional or physician. Such youth include those who exhibit immediate threat to themselves or others and for whom out-of-home placement appears imminent. Program staff must be able to triage and have the capacity to make appropriate clinical disposition decisions, including accessing inpatient services if needed, or less restrictive alternatives.~~

~~Providers certified as community mental health centers (DMH-C option) must provide emergency services, including standards pertaining to telephone emergency assistance as described in Standards 1800.0 – 1800.6 that follow.~~

~~1800.0 The provider must have current written interagency agreement(s) or contract(s) with licensed hospitals to provide emergency room services that, at a minimum, address the following:~~

~~a. Availability of hospital emergency room services to address needs of individuals experiencing a mental health emergency/crisis;~~

~~b. Availability of face-to-face contact with a mental health professional, including specifically the availability of mental health professional consultation for youth admitted to the hospital for medical treatment of suicide attempts or other psychiatric emergencies.~~

~~1800.1 The provider must insure that the opportunity for face-to-face contact with a mental health professional is available twenty-four (24) hours a day/seven (7) days a week.~~

~~1800.2 Providers must maintain a staff roster and twenty-four (24) hour on call schedule for addressing emergencies, including emergencies that occur Aafter hours.@ In community mental health centers, this time period is any time during which the main administrative office of the center is not operational and/or open to the public.~~

~~1800.3 Emergency service availability must be publicized, including a listing in the telephone directories for the area served by the program.~~

~~1800.4 Providers of emergency services must maintain a written, daily log of emergency face-to-face and telephone contacts, including, at a minimum:~~

~~a. Identification of child/youth and/or family member(s) involved in the emergency/crisis;~~

b. Time and date of emergency face-to-face contact and/or telephone contact;

c. Presenting problem(s);

d. Action(s) taken by emergency services staff;

e. Documentation of notification and involvement of significant others, and when contact is deemed inappropriate, indication of why notification was not made.

f. Disposition or resolution of the emergency/crisis, including:

(1) Condition of the child/youth and/or family member(s) at the last face-to-face contact and/or termination of the telephone call; and,

(2) Services to which the individual and/or family was referred.

g. Name and position of staff member(s) addressing the emergency.

1800.5 There must be documentation of staff assigned to emergency services trained and knowledgeable in the policies and procedures required for pre-evaluation screening and civil commitment.

1800.6 Twenty four (24) hour telephone emergency service must be available and must at a minimum:

a. Provide for collect calls and/or toll-free telephone line(s);

b. Be documented in the daily log;

c. Assure that the caller does not have to make more than two (2) telephone calls to reach an emergency worker.

SECTION E - MOBILE CRISIS RESPONSE SERVICES

Mobile crisis response services involve immediate face-to-face service encounter(s) at sites in the community other than the provider's service location (such as at the youth's home, school, etc.) and be a component of a crisis response program. Typically, the distinguishing characteristic of mobile crisis services is that the mental health staff go to

~~the location of the youth/family in crisis, rather than the youth/family going to the mental health staff's location. Children/youth requiring mobile crisis services are those who are experiencing a significant emotional crisis(es) and who may be in imminent danger of harming self or others as determined by a mental health professional or physician.~~

~~1900.0 Providers of mobile crisis services also must meet Minimum Standards 1800.0 - 1800.6 for emergency services.~~

~~1900.1 Providers of mobile crisis services must provide at least one immediate face-to-face service encounter at designated locations~~ outside ~~the mental health providing agency, including the child's/youth's home and/or other accessible and appropriate sites in the community.~~

~~1900.2 Staff providing mobile crisis services must be appropriately certified or licensed in the State of Mississippi to administer necessary emergency mental health treatment with access to arrangements for medical care, as needed at the time of the mobile crisis contact.~~

~~1900.3 Providers must maintain flexible hours for the mobile crisis service, which allow for twenty-four (24) hour service availability, seven (7) days a week.~~

~~1900.4 The provider must provide or have access to all appropriate mental health services and/or follow-up monitoring; i.e., case management, outpatient therapy, day treatment, therapeutic residential services, acute inpatient services, residential treatment center services, and family support.~~

SECTION ~~F~~ B- INTENSIVE CRISIS INTERVENTION SERVICES (Children & Youth)

VIII.B.1. Intensive Crisis Intervention Services for children and youth refer to specialized, time-limited interventions, available twenty-four (24) hours, seven (7) days/week, from some providers through program grants from the Mississippi ~~Department of Mental Health~~ DMH, Division of Children and Youth. ~~Intensive Crisis Intervention Services can be delivered as a separate crisis response and treatment service or as a component of a crisis residential service~~.

VIII.B.2. Expected outcome of intensive crisis intervention services for children and youth is a child/youth experiencing a crisis obtains the support needed in order to diffuse the crisis in a manner that will maintain the child/youth in his/her home and community setting.

VIII.B.3. ~~2000.0~~ Providers that receive special grant funding from the Mississippi ~~Department of Mental Health~~ Division of Children and Youth for Intensive Crisis Intervention Services, must also comply with Emergency/Crisis Services standards ~~above~~ (Part VIII, Section A) and any additional specifications set forth in individual program grants.

~~2000.1 Providers of Intensive Crisis Intervention Services must document how services are coordinated across service disciplines.~~

VIII.B.4. ~~2000.2~~ Providers of Intensive Crisis Intervention Services must, at a minimum, provide access to Case Management and Outpatient Mental Health Therapy Services.

VIII.B.5. Providers must include documentation in the child/youth's chart that they have entered Intensive Crisis Intervention Services and must have a plan in place for transition into individual services.

~~SECTION G - CRISIS RESIDENTIAL TREATMENT SERVICES~~

XI.J.5. Crisis Residential Treatment Services (excludes inpatient and psychiatric residential treatment ~~centers~~ facilities licensed and certified by the Mississippi State Department of Health) provide brief assessment with immediate and intensive residential treatment services, typically followed by intensive outreach/aftercare treatment. Providers that make available a residential treatment component as part of a comprehensive emergency/crisis response program must also meet the minimum standards in this section. Additionally, providers of Crisis Residential Treatment Services for C/Y must also meet the standards in Parts VIII, Sections A and B.

XI.J.9. ~~2100.0~~ Children/youth served by the crisis residential treatment program must meet the following eligibility criteria:

a. Under the age of ~~eighteen (18)~~ nineteen (19) years and within a developmentally appropriate age range to benefit from the services of the program as specified/determined by the program;

b. Designated staff confirm that the individual is experiencing severe, demonstrable emotional crisis(es), ~~confirmed by designated staff of the program to be experiencing a crisis~~ that can be appropriately addressed through the specific services provided by the program;

~~c. Have an emotional or mental disorder as defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or subsequent editions or are at significant risk of having such a diagnosis; and,~~

~~d.~~ c. ~~Whose~~ The condition/situation indicates that crisis residential treatment could divert them from inpatient care or other more restrictive placement.

XI.J.10. ~~2100.1~~ Crisis residential treatment programs must provide the following services:

~~a. Mobile crisis response services (Section E);~~

~~b. Telephone emergency assistance services (Section D);~~

c. Medical and psychological evaluation and assessment by appropriately certified individuals of the need for referral to other specialized treatment programs or services (such as alcohol/drug treatment);

d. Psychiatric consultation;

e. Medication management;

~~f. Crisis counseling, for both individuals/families who need crisis residential placement, and those who, after assessment do not need residential placement, but do need mental health intervention to address the crisis;~~

g. Case Management;

h. Family education and counseling;

~~i. Access to emergency medical and dental services;~~

j. Access to intensive crisis intervention aftercare;

~~k. Discharge planning and referral.~~

~~2100.2 The program must provide or have access to, through affiliation agreements with other providers, other services (not listed above) in the Ideal Model of the Comprehensive System of Care for Children with Serious Emotional Disturbance (in the current State Plan for Community Mental Health Services). These services must be available in the community within a 100-mile radius of the child/youth's family/primary residence.~~

2100.3 The crisis residential facility must be equipped with an operable electronic security system that has the capacity to monitor unauthorized entrance or egress, or movement through the facility or secure areas, by use of window, door, and motion detectors, etc.

XI.J.3. ~~2100.4~~ The ~~crisis~~ residential facility (all types) must have emergency exit doors operated by a magnetic/electronic release system. This system must be in a secured location that is readily accessible only by staff.

~~2100.5 The policy and procedures manual for the program must include procedures for conducting searches of the person(s), room(s) and/or personal possessions of individuals served in the crisis residential program, including typical reasons for such searches, designation of program staff who can authorize such searches and documentation of such searches in individual case records.~~

~~2100.6 Whenever there is a reason to believe that the security of a crisis residential facility or the health or safety of anyone is endangered, a search of each child's/youth's person, room, locker, or possessions can be conducted if authorized by the residential program director or designee, as defined in program policies and procedures. The reason for the search must be documented and maintained in the record of each child/youth whose person, room, locker or possessions were searched.~~

~~2100.7 Each crisis residential treatment program must maintain on-site an updated program manual that includes, at a minimum, the following:~~

~~a. The mission statement of the program, including its philosophy, purpose and overall goals;~~

~~b. Description of the typical characteristics and needs of youth/families served by the program;~~

~~c. Description of the program's components or services, including the minimum levels of staffing required for protection and guidance of youth to be served in the program;~~

~~d. Procedures for handling after-hours and weekend emergency admissions;~~

~~e. Procedures for ensuring the safety and well-being of children/youth who are experiencing a crisis, including procedures for the following:~~

(1) Notification of the program's attending physician;

(2) Implementation of programs and staff training for addressing potentially dangerous behaviors (such as aggression, suicide, etc.);

(3) Observation of children/youth experiencing a crisis;

(4) Determining the need for and development, implementation and supervision of behavior change/management programs;

(5) Therapeutic modalities and treatment activities (including age-appropriate activities) used in the program.

f. Implementation of written procedures, reviewed and approved by a licensed physician, that address minimum standards in Part III, Section F - Medication Control and the following:

(1) Medication management;

(2) Personal hygiene care and grooming;

(3) Prevention of and protection from infection, including communicable diseases;

(4) Protocols for ordering, implementation and documentation associated with the use of restrictive procedures.

2100.8 The provider must document that the following information has been provided in writing and explained in a manner easily understood to parent(s), legal guardian(s) and youth being served in the crisis residential program, as part of information provided to youth, parent(s)/legal guardian(s) prior to or upon admission to the program:

a. Program rules, including those regarding visitation and consequences of noncompliance with rules; goals and critical components of the treatment program; and, expectations regarding participation in the program by parent(s)/legal guardian(s);

b. Information regarding out-of-facility activities;

~~c. Information concerning the school/educational services that may be provided for the child/youth while he/she is in the crisis residential program; and,~~

~~d. Review of visitors, callers, relatives, or others who are identified as required "no contact" with the child/youth.~~

~~2100.9 The provider must ensure that each child/youth served in crisis residential program(s) has clean, comfortable, well-fitting clothes and shoes.~~

XI.J.12. ~~2101.0~~ Team meetings of designated treatment and other staff, as needed by individual youth, must be held every three days during the youth's stay to assess progress toward objectives on the Individualized ~~Treatment~~ Service Plan and to make any revisions necessary to continue effective treatment. Attempts must be made and documented as part of ~~treatment~~ Individual Service plan development/ revision to include the presence and/or input of parent(s)/legal guardian(s) and youth (as developmentally appropriate) at team meetings.

~~2101.1 The provider must maintain updated daily and weekly schedule(s) of activities that reflect group activities and routines, as well as individually planned activities for the children/youth served in the program. Daily and weekly schedule(s) of activities must be maintained on file for at least three months. Group activities must be related to implementation of objectives in individualized treatment plans of youth served in the crisis residential treatment program. (See also Standards 1501.1 - 1501.2.)~~

XI.J.13. ~~2101.2~~ The child's/youth's stay in the crisis residence must not extend beyond a maximum of ~~fourteen (14)~~ twenty-one (21) consecutive days ~~without approval by the Mississippi Department of Mental Health.~~ An extension of this timeframe should be submitted in writing to the Director, Bureau of Community Services for approval by the DMH Review Committee**.**

XI.J.14. ~~2101.3~~ If a child/youth is readmitted to the crisis residential program at any time after a previous discharge from the program, they must be evaluated for and again meet eligibility criteria specified in Standard ~~2100.0~~. **XI.J.9.**

~~2101.4 The staffing plan for crisis residential treatment programs, including credentials of staff to be employed and shift/duty assignments,~~

~~must be submitted to the Mississippi Department of Mental Health (with application for certification) and approved prior to youth being admitted to the home.~~

~~2101.5* The provider must ensure that the staff on-site are of a sufficient number to provide adequate supervision of youth in a safe, therapeutic home environment and must meet the following minimum requirements:~~

~~a. At least two (2) staff for every five (5) youth must be assigned to direct service responsibilities during all hours. One (1) of the two (2) staff can be a direct care worker and (1) one must be a professional staff member with at least a Bachelor's degree in a mental health or related field.~~

~~b. Other appropriate professional staff, with at least a Master's degree in a mental health or related field must be available to assist in emergencies, at least on an on-call basis, at all times.~~

~~c. The Mississippi Department of Mental Health may require a staff to youth ratio higher than described in Standard 2101.5 a.- b. above, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of youth served by the individual home.~~

~~2101.6 The provider must ensure that direct care or house parent staff providing on-site direct services as described in Standard 2101.5 meet the following minimum qualifications:~~

~~a. A high school or equivalent diploma; and,~~

~~b. At least one year of experience in working with youth.~~

XI.J.8. ~~2101.7*~~ The provider must ensure that an adequate number of professional staff are available and on-site and are qualified by training and experience to provide programmatic direction and supervision. The staffing composition pattern will be subject to approval by the ~~Department of Mental Health~~ DMH Director, Bureau of Community Services, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of youth served by individual homes. The staffing composition of all crisis residential treatment programs must include, at a minimum, the following:

a. A full-time director who is on-site, at least forty (40) hours per week, and who meets the following minimum qualifications as stated in Standard VI.C.1(a);

~~(1) Master's degree in the behavioral sciences or a mental health field and other qualifications as required by funding source(s); and,~~

~~(2) At least one year of documented experience and/or training necessary to manage and supervise residential or inpatient programs for children/youth with serious behavioral/ emotional disorders.~~

b. Availability of a licensed psychiatrist with experience working with children/adolescents, on an employment or contractual basis.

c. A full-time mental health therapist who is on-site, at least forty (40) hours per week, and who meets the following minimum qualifications as stated in Standard VI.C.1(h).

~~(1) Master's degree in mental health or related field and other qualifications as required by funding source(s); and,~~

~~(2) Documented experience or training in therapeutic intervention/treatment of children with serious behavioral/emotional disorders.~~

d. Availability of an additional mental health professional staff person, with at least a Bachelor's degree in a mental health or related field, if needed to meet staffing requirements ~~described in previous Standard 2101.5.~~

~~2101.8 If psychiatric services are obtained on a contractual basis from a community mental health center or other provider agency, there must be in place a current, written interagency agreement between the provider of the crisis residential treatment program and the provider of the psychiatric services that addresses, at a minimum, the following:~~

~~a. Availability of a psychiatrist who meets minimum qualifications as set forth in previous Standard 2101.7; and,~~

~~b. Procedures for obtaining necessary informed consent, including consent for release and sharing of information from the mental~~

health center and the provider of the crisis residential treatment program.

2101.9 The provider must conduct an annual evaluation of the program and based on this evaluation must review, develop, and implement indicated program and administrative changes in accordance with the defined mission of the program.

2102.0 The outcome-based evaluation system must address a variety of measures, which must include at lest two of the following:

a. The number of admissions to inpatient psychiatric hospitals or residential treatment centers;

b. The number of pre-evaluation screenings for civil commitment;

c. Satisfaction surveys, family and/or child/youth;

d. Recidivism rates of youth utilizing the service;

e. Prevention of child placement in DHS custody.

SECTION H - CASE MANAGEMENT SERVICES

Case Management is the provision and coordination of services that are an integral part of helping individuals access needed medical, social, educational, and other services in order to attain their highest level of independent functioning. Activities include individual's identification, assessment, reassessment, service planning, referral, service delivery monitoring, and supportive counseling as well as outreach services designed to seek out and engage persons who are eligible for case management including children with a serious emotional disturbance.

2200.0 The following children/youth with serious emotional disturbance (as defined in Standard 1500.2) must be evaluated for the need for case management and provided case management, if needed based on the evaluation, unless the service has been rejected in writing by the parent(s)/legal guardian(s):

a. Children and youth who have a serious emotional disturbance and receive substantial public assistance. (Public assistance is defined Medicaid);

b. Children/youth with a serious emotional disturbance who are receiving intensive crisis intervention services.

c. Children/youth with a serious emotional disturbance referred to the community mental health center after discharge from inpatient psychiatric care, residential treatment care, and therapeutic group homes (within two weeks of referral for community mental health services).

2200.1 Case management must be offered to the parent(s)/legal guardian(s) of youth at a minimum, every twelve (12) months, if their child continues receiving any mental health service continually for twelve (12) months or longer.

2200.2 In addition to complying with the appropriate areas of the current Minimum Standards for Community Mental Health/Mental Retardation Services, a program must comply with any special guidelines for case management issued by the Department of Mental Health for the operation of the case management program.

2200.3 Providers of mental health case management for children/youth must, at a minimum:

a. Maintain an established case management unit, with a full-time case management supervisor;

b. Assign a full-time case manager to youth accepted for case management services;

c. Limit the caseload for a single case manager to fifty (50) (Combined case loads (SMI/SED) for children's case management shall now exceed a total of 50.); and,

d. Maintain on file (available for review) a current list of each case manager's caseload.

2200.4 The case management program must maintain a current, comprehensive file of available community resources that is readily accessible to all case managers. This resource file must include at a minimum:

a. Name of resource/agency;

b. Eligibility requirements for resource(s)/agency(ies);

c. Contact person for resource(s)/agency(ies);

d. Services available through the resource(s)/agency(ies);

e. Phone number(s) of resource(s)/agency(ies).

2200.5 Efforts to obtain input into the development of individual treatment plan(s) of youth enrolled in case management from the following representatives must be documented:

a. Representative(s) of the Mississippi Department of Human Services (DHS) for children/youth in DHS custody or under their supervision;

b. Representative(s) of the child's/youth's local school.

2200.6 Input of the parents in the development of individual treatment plan(s) from parent(s)/legal guardian(s) of youth enrolled in case management must be documented.

2200.7 Case records for children/youth with whom no case management contact has been documented for twelve (12) months must be closed after a documented effort to contact the individual.

2200.8 In addition to components described in General Standards for Mental Health Service for Children and Youth Services, the written policy and procedure manual for the operation of case management services must also include the following areas:

a. Specific strategies to be used for outreach to the target population for case management services;

b. Formal and informal linkages and coordination efforts with appropriate services in the community, including referral process(es).

2200.9 Parent(s)/legal guardian(s) of children/youth being discharged from public inpatient psychiatric care must be offered an evaluation to determine the need for case management services within two weeks after referral for community services.

2201.0 Case Managers are required to participate in the Department of Mental Health sponsored orientation within six (6) months following date

of hire, including the staff development opportunities and meetings as required by the Department of Mental Health.

SECTION I - DAY TREATMENT SERVICES

Day treatment is a therapeutic service designed for individuals who require less than twenty four (24) hour-a-day care, but more than other less intensive outpatient care. Intensity and duration of the child's/youth's problem(s) are key factors in determining the need for day treatment. Day treatment is a behavioral intervention program, provided in the context of a therapeutic milieu, which provides children/adolescents with serious emotional disturbances the intensity of treatment necessary to enable them to live in the community. The program is based on behavior management principles and includes, at a minimum, positive feedback, self-esteem building and social skills training. Additional components may include skills training in the areas of impulse control, anger management, problem-solving, and/or conflict resolution. Day treatment is the most intensive outpatient program available to children and adolescents and should provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services.

2300.0 Justification of the need for day treatment services, including intensity and duration of problems, must be documented as part of the intake/assessment.

2300.1 Each day treatment program must be designed to provide a community-based alternative to inpatient treatment and/or aid in making the transition from inpatient treatment to other community-based, less intensive outpatient services.

2300. 2 Each day treatment program must be designed as a therapeutic milieu and should 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. All activities and strategies implemented must be therapeutic and directly related to the individual objectives on each individual's comprehensive treatment plan.

2300.3* Each 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 youth must receive day treatment services 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.~~

~~2300.4* The program must operate at any one (1) time with a minimum of four (4) youth and a maximum of nine (9) youth.~~

~~2300.5* To ensure each individual's confidentiality, no children/youth other than those enrolled in the day treatment program can be present in the room during the time day treatment is being provided.~~

~~2300.6* Only one (1) day treatment program (4 to 9 youth) is allowed per room during the same time period.~~

~~2300.7* Each day treatment program (4 to 9 youth) must have a Master Schedule posted at each location and must include, at a minimum, the specific skill areas being addressed each day and the specific times these skill areas are being addressed. Client identification numbers must be listed for all clients participating in each skill area (time period) being addressed. If different skill areas are being addressed on different days of the week, the Master Schedule must reflect this.~~

~~2300.8 The provider must maintain schedule(s) of activities that reflect day treatment activities. Schedule(s) of day treatment activities must be maintained on file for at least three (3) months. Day treatment activities must be related to implementation of objectives in individualized treatment plans of youth served in the program.~~

~~2300.9 Each day treatment program will have a name. If a program is located in a school, it will be named after the school. If a program is located at a site(s) other than a school, the program will be named after the county in which it is located. The program's name, along with the physical address of the respective building, will be placed on the program's certificate. For more than one (1) program located at the same site, each will be numbered consecutively, beginning with Roman numeral I. Examples:~~

~~School-based~~
~~Hazlehurst Elementary I (4 to 9 clients)~~
~~Hazlehurst Elementary II (4 to 9 clients)~~

~~Satellite~~
~~Clay County I (4 to 9 clients)~~
~~Clay County II (4 to 9 clients)~~

~~2301.0 Each day treatment program must comply with the following:~~

a. Twenty (20) square feet of usable space per child;

b. In cases of school-based programs, the mental health provider is responsible for insuring that the school district provides a site or facility that meets all standards in Part III, Section A-Environment/ Safety.

2301.1 The program must have a day treatment program manual at each program location that must include, but is not limited, to the following:

a. The placement of the program within the agency's organizational structure;

b. The program's purpose, goals and objectives;

c. The population the program will serve (e.g., the age range, diagnostic categories, special targeted populations, etc.);

d. Description of procedures for determining the need for and development, implementation and supervision of behavior change/ management programs;

e. The therapeutic modalities and treatment activities used in the program;

f. The strategies the program will use to divert clients from residential treatment, or, how the program will serve as an alternative to and/or transition from residential treatment;

g. The screening, selection, admission, and discharge procedure;

h. Program policies and procedures.

2301.2* A staff member with a minimum of a Master's degree in mental health or a related field must be designated to supervise, plan, coordinate, and evaluate day treatment services for children/youth. This supervisor must provide each day treatment program (4 to 9 youth) with, at a minimum, one (1) continuous hour of assistance each week, which must be documented. Documentation, which must be maintained on file for review, must reflect topics, cases and activities discussed and/or the type of assistance provided to the day treatment program staff. At least one (1) continuous hour per month must be spent observing the program in operation.

~~2301.3 All staff members providing direct day treatment services for children and youth, employed after the effective date of these standards must have a Master's degree in a mental health or related mental health field and (1) a professional license (ex. Licensed Professional Counselor, Psychologist, Licensed (Master's level) Social Worker or Physician) or (2) hold DMH credential as a Mental Health Therapist or a Mental Retardation Therapist, as appropriate to the population served. Staff employed before that date must obtain a Master's degree in a mental health field and (1) a professional license (ex. Licensed Professional Counselor, Psychologist, Licensed (Master's level) Social Worker, or Physician) or (2) hold DMH credential as a Mental Health Therapist or Mental Retardation Therapist, as appropriate to the population served, before July 1, 2004.~~

~~2301.4 The ratio of staff to clients in each day treatment program will be maintained at a minimum of two (2) on-site staff persons to a minimum of four (4) up to a maximum of nine (9) children/youth per program. Direct service delivery staff may be assisted by another staff person with at least a minimum of a high school diploma and evidence of having worked at least one year with children/adolescents.~~

~~2301.5 The Division of Children and Youth must be notified of any interruption of service extending over fifteen (15) days. If the program has been closed for thirty (30) calendar days, the Certificate of Operation must be returned to Division of Accreditation and Licensure, unless conditions for school-based programs in Standard 2301.6 apply/are met.~~

~~2301.6 Day treatment programs that are unable to provide services during a school's summer vacation will be allowed to hold that program's Certificate of Operation until the program can be reopened the following school year, which must be within thirty (30) calendar days from the first day of school. If the program has not reopened within thirty (30) calendar days from the first day of the school year, the Certificate of Operation must be returned to the Mississippi Department of Mental Health, Division of Accreditation and Licensure.~~

~~2301.7 Mental health services must be offered for the youth to parent(s)/legal guardian(s) during the summer vacation time the day treatment program is temporarily not operational (described in 2301.6). These services may include day treatment services, if needed, provided at other sites maintaining program capacity requirements. Documentation must be maintained that availability of such services was explained and~~

~~services were offered to the parent(s)/legal guardian(s); refusal of such services must be documented by the parent/legal guardian signature.~~

~~2301.8 Day treatment programs operated in a school must insure that day treatment services continue to adhere to all Department of Mental Health Minimum Standards for this service. Day treatment services are considered a separate program from educational programs. In addition, any educational program must meet applicable standards and regulations promulgated by the State Department of Education.~~

~~NOTE: Providers of Acute Partial Hospitalization services for children must meet standards for that service under Part VIII Adult Community Mental Health Services, Section K.~~

SECTION ~~J~~ E- RESPITE CARE SERVICES

XV.E.1. Respite care is a planned break for parents who are caring for a child/youth with emotional/behavioral problems. Respite care can be used by biological, adoptive, and foster parents and can occur as frequently as weekly. Trained respite parents or counselors assume the duties of care-giving and supervising youth for a brief period of time in order to allow the parents a break from the constant strain of parenting a child with serious emotional problems.

XV.E.2. The expected outcomes for Respite Care Services include:

a. Children/youth have increased access to care which minimizes crisis situations.

b. Children/youth and their families receive Respite Services are individualized and tailored to meet the needs of children/youth and their families.

XV.E.3. ~~2400.0~~ 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.

XV.E.4. ~~2400.1 In addition to components described in General Standards for Mental Health Service for Children and Youth Services~~ In addition to the requirements in Part II, 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;

c. Description of procedures for determining the need for and development, implementation and supervision of behavior change/ management programs for children/youth served on a regular basis.

XV.E.5. ~~2400.2~~ Providers of respite services must maintain documentation of linkages with other health and social service agencies, particularly those that serve children/youth.

XV.E.6. ~~2400.3~~ 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.

XV.E.7. ~~2400.4~~ 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 guardian(s) and youth being served in the program, as part of information provided to youth, parent(s)/legal guardian(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. Rights of individuals served in the program (as specified in Part ~~III, Section C~~ V, Rights of Individuals Receiving Services), including the name of the person or office the parent(s) or guardian(s) may contact if they feel their child's rights have been violated.

XV.E.8. ~~2400.5~~ 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 ~~II~~ VI - Section ~~E~~ D, Training and Staff Development and Part V, Rights of Individuals Receiving Services.

(including Rights of Individuals Receiving Services) and prohibited punishments, as specified in Part VI - Mental Health Services for Children and Youth, Section A - General Standards.)

SECTION K - OUTPATIENT THERAPY SERVICES

Outpatient treatment of individual, group, and multi-family group therapies (excluding day treatment and case management) are the least intensive and most typically used interventions in the mental health field.

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

Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2) but no more than eight (8) children 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.
Multi-Family Group Therapy is defined as psychotherapy that takes place between a mental health therapist and family members of at least two 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.

2500.0 Outpatient services must be available and accessible at appropriate times and places to meet the needs of the population to be served. The program must establish some regular hours for evenings and/or weekends for children/youth and/or their families.

2500.1 Specific outreach strategies to be used must be developed, defined and implemented to serve children/youth and their families.

2500.2 The provider of outpatient services must describe the range of diagnostic and treatment modalities, as well as family education and support services, to be offered.

2500.3 The provider of outpatient services must have a written plan for services that identifies the manner in which each of the following special target populations of children/youth will be served:

~~a. Children/youth with a serious emotionally disturbance;~~

~~b. Children/youth with a dual diagnosis (SED/A&D);~~

~~c. Children/youth discharged from psychiatric inpatient care and residential treatment facilities;~~

~~d. Children/youth transitioning from therapeutic group homes and therapeutic foster care;~~

~~e. Children/youth who are homeless;~~

~~f. Youth with serious emotional disturbance in transition from the children/youth services system to the adult service population.~~

~~2500.4 The provider must have implemented policies and procedures that ensure that, at a minimum, for youth being discharged from inpatient care, residential treatment centers and therapeutic group homes:~~

~~a. The youth (and family member(s) as appropriate) are given an appointment with a mental health professional within two weeks after referral;~~

~~b. The youth (and family member(s) as appropriate) are given an appointment with a physician within four (4) weeks after referral;~~

~~c. The youth (and family member(s) as appropriate) are evaluated for and/or enrolled in case management services within two (2) weeks after referral for community services;~~

~~d. Inpatient referral facilities have current contact office and phone number information so that aftercare appointments are made within the above required time frames; and,~~

~~e. Professional staff have been trained and are knowledgeable in the policies and procedures in a.-d. above.~~

SECTION ~~L.~~ B- FAMILY SUPPORT AND EDUCATION SERVICES

XV.B.1. Family Support and Education Services, which provide self-help and mutual support for families of youth with mental illness or emotional disturbances, are based on the view that individuals with similar circumstances have the capacity to understand and assist

each other, and that the support of other concerned individuals is a great asset in helping to cope with difficulties.

XV.B.2. The expected outcomes for Family Support and Education Services include:

a. Families of children/youth with serious emotional disturbance(s) will be better able to access services.
b. Families of children/youth with serious emotional disturbance(s) will obtain support and develop coping mechanisms needed to deal with their child's/youth's disorder.

~~Family support and education services for families of children/youth with behavioral/ conduct, emotional disturbance or mental illness must meet the following DMH Standards to be certified.~~

XV.B.3. ~~2600.0~~ 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.

XV.B.4. ~~2600.1~~ 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:

a. Description of individuals targeted to receive family support and education services;

b. Specific strategies to be used for outreach to the target population for family support and education services;

c. Description of qualifications and specialized training required for family support and education providers;

d. Description of service components of the family support and education program.

XV.B.5. ~~2600.2~~ 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 or types of presentations with an individual family or groups of families. At

a minimum, these activities must address one or more of the following or other DMH pre-approved topics:

a. Identified methods and approaches commonly used to identify children/youth with behavioral, conduct or emotional disorders;

b. Development of a family action plan;

c. Prevalent treatment modalities;

d. Common medications;

e. Child development;

f. Problem-solving;

g. Effective communication;

h. Identifying and utilizing community resources;

i. Parent/professional collaboration;

j. Overview of a collaborative service network;

k. Consultation and education; and,

l. Pre-evaluation screening for civil commitment for ages 14 and up.

SECTION C- MAP TEAMS

XV.C.1. MAP Teams address the needs of children, up to age 21 years, with serious emotional/behavioral disorders, including, but not limited to, conduct disorders, or mental illness, who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

XV.C.2. The expected outcomes for MAP Teams include:

e. Children/youth will be served and remain in their homes and communities.
f. Families will be referred to community resources provided by multiple local agencies and entities.
g. Children/youth will be prevented from utilizing placements to Psychiatric Residential Treatment Facilities (PRTF) in order to access needed services and supports.

h. Children/youth will be successfully transitioned back into their homes and communities from inpatient care.

XV.C.3. All providers certified as community mental health centers (DMH-C) must make available or participate in at least two (2) Making a Plan (MAP) Teams in each community mental health region.

XV.C.4. Each MAP Team must be comprised of, at least, one child behavioral health representative employed by the Regional CMHC with a Bachelor's degree. In addition, there must be at least one representative from each of the following:

a. Each local school district in a county served by a MAP Team;

b. County Family and Children's Services Division of the State Department of Human Services;

c. County or Regional Youth Services Division of the State Department of Human Services; and,

d. County or Regional Office of the State Department of Rehabilitation Services.

e. County or Regional Office of the Mississippi State Department of Health; and,

f. Parent or family member with a child who has experienced an emotional and/or behavioral disturbance.

g. 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.

XV.C.5. The community mental health center (DMH-C) must maintain a current written interagency agreement with agencies participating in the MAP Team.

XV.C.6. A CMHC Master's level therapist must participate in the regional A Team Meetings that are held within their catchment areas. *(Please refer to the DMH Division of Children and Youth Services Directory for definition and locations of A-Teams.)*

SECTION D- FETAL ALCOHOL SPECTRUM DISORDERS (FASD) SCREENING, DIAGNOSIS AND TREATMENT SERVICES

XV.D.1. 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. FASD occurs in about 1% of all live births, or about 450 to 500 new cases in Mississippi per year. FASD now outranks Down syndrome and autism in prevalence. The Institute of Medicine reported to Congress that "Of all the substances of abuse (including cocaine, heroin, and marijuana), alcohol produces by far the most serious neurobehavioral effects in the fetus." The damage caused by prenatal alcohol exposure is permanent. The effects cannot be reversed, but many of them can be treated with the appropriate combination of interventions and support. Secondary disabilities of FASD include mental health issues (90%), school problems (60%), trouble with the law (60%) and attempted suicide (23%). 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.

XV.D.2. Expected outcomes for FASD Screening, Diagnosis and Treatment Services include:

a. Children with a FASD will experience a reduction in the occurrence and impact of the secondary disabilities associated with a FASD.

XV.D.3. 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 FASD if there is indication of prenatal alcohol exposure.

XV.D.4. The FASD screening tool will be provided to entities certified under the DMH/C option by the Division of Children and Youth Services (see the DMH Record Guide). The screening may be conducted by a case manager, a therapist, or other children's mental health professional.

XV.D.5. 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.

XV.D.6. Results of the FASD screening and FASD diagnostic evaluations, if indicated, must be reflected in the child's Individual Service Plan and/or case management service plan. If a child receives a fetal alcohol-related diagnosis, it should be recorded on the appropriate Axis.

XV.D.7. If a child's initial FASD screening result is negative, the screening process must be repeated at the annual case review to determine if additional information regarding maternal alcohol history has been obtained that might change the results of the initial FASD screen.

XV.D.8. With consent obtained from the parent/legal guardian, children 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. With consent obtained from the parent/legaul guardian, a CMHC staff person must accompany the child and parent/guardian to the diagnostic appointment in order to participate in the child's history interview and the informational interview.

XV.D.9. Treatments and interventions recommended by the FASD multi-disciplinary diagnostic team must be either provided or facilitated by the CMHC mental health professional, as applicable to the identified scope of practice for the mental health professional. Referral to the local MAP Team should be made when appropriate.

XV.D.10. Because children with an FASD often do not respond to traditional mental health services and/or treatments, children's mental health services may need to be modified in order to be more effective for children with an FASD.

XV.D.11. 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.

~~PART VII~~

~~ALCOHOL AND DRUG SERVICES~~

PART XVIII

SUBSTANCE ABUSE PREVENTION AND REHABILITATION SERVICES

All sections contained in this part pertain specifically to services and supports that are available to individuals with substance abuse disorders or activities designed to prevent substance abuse.

~~All alcohol and drug treatment and prevention programs that receive funds from and/or are certified by the Department of Mental Health, Division of Alcohol and Drug Abuse must comply with the standards in Part I – Procedures for Certification, Part II – Organization and Management, Part III – Human Services, Part V – Bureau of Mental Health General Standards, Part VII – Alcohol and Drug Services, and applicable sections in Part X – Other Community Services for Individuals with Mental Illness, Mental Retardation/Developmental Disabilities, or Substance Abuse.~~

Primary substance abuse treatment consists of the following: Primary Residential Treatment, General Outpatient, Intensive Outpatient (IOP), Inpatient Chemical Dependency Unit (CDU) and Specific Outpatient ADUI program@ Tracks. Transitional Residential substance abuse treatment is also referred to as Secondary substance abuse treatment. The DMH Substance Abuse support service is Aftercare. Alcoholic Anonymous, Alanon, and other self-help groups are also considered substance abuse support services.

All alcohol and drug treatment and prevention programs that receive funds from and/or are certified by the DMH, Bureau of Alcohol and Drug Abuse must comply with the Standards in Parts I through VII.

SECTION A- GENERAL STANDARDS

XVIII.A.1. ~~2700.0~~ All DMH funded service providers of an alcohol and drug program must submit the Mississippi Substance Abuse Management Information System (MSAMIS) report to the ~~Department of Mental Health, Division~~ DMH, Bureau of Alcohol and Drug Abuse by the tenth (10th) working day of the month following the reporting period.

~~2700.1 The program must have written policies and procedures for admission which:~~

~~a. Describe the process for admission to the program;~~

~~b. Define criteria for admission and readmission to the program;~~

~~c. Describe the process to be followed when an individual is found ineligible for admission;~~

~~d. Describe the procedure for the intake process;~~

~~e. Assure equal access to treatment and services for individuals with disabilities who are otherwise eligible;~~

~~f. Describe the procedure for individuals who are ordered to treatment by the court system;~~

~~g. Assure equal access to treatment and services for HIV-positive persons who are otherwise eligible.~~

XVIII.A.2. ~~2700.2~~ The program must have written policies and procedures for the discharge of an individual from a program including, but not limited to the following:

a. Successful completion of treatment;

b. Noncompliance with program rules and regulations;

c. Transfer of individual to another program;

d. Instances in which the individual leaves a program (self-declared discharge) against the advice/approval of program director or designee.

XVIII.A.3. ~~2700.3*~~ All providers must provide and document that all individuals receiving primary substance abuse treatment receive a risk assessment for HIV at the time of intake. Those individuals determined to be high risk for HIV must be informed of available HIV testing resources. Transitional residential and aftercare programs must also provide these services unless the program can provide documentation that the individual received the risk assessment and follow-up (as needed) during primary substance abuse treatment. Individuals in a residential setting that volunteer to be tested must be offered transportation to an appropriate health care facility.

XVIII.A.4. ~~2700.4*~~ All providers must provide and document that all individuals receiving primary substance abuse treatment receive a risk assessment for Tuberculosis (TB) at the time of intake. All appropriate TB tests (skin tests, chest x-rays) must be provided by the agency, or by an appropriate health care agency, to all individuals determined to be high risk. Transitional residential and aftercare programs must also provide these services unless the program can provide documentation that the

individual received the risk assessment and follow-up (as needed) during primary substance abuse treatment. Individuals in a residential setting must be provided with necessary transportation.

XVIII.A.5. ~~2700.5*~~ All providers must provide and document that all individuals receiving primary substance abuse treatment receive educational information concerning the following topics in a group and/or individual session.

a. HIV/AIDS;

(1) modes of transmission;

(2) Universal Precautions and other preventative measures against contracting/spreading the virus;

(3) current treatments and how to access them.

b. Tuberculosis (TB);

(1) modes of transmission;

(2) current treatment resources and how to access them.

c. Sexually Transmitted Diseases (STDs);

(1) modes of transmission;

(2) precautions to take against contracting these diseases;

(3) progression of diseases;

(4) current treatment resources and how to access them.

XVIII.A.6. Transitional residential and aftercare programs must also provide ~~this service~~ the service outlined in Standard XVIII.A.5, unless the program can provide documentation that the individual received the educational information during primary substance abuse treatment.

XVIII.A.7. ~~2700.6*~~ All substance abuse programs must give first priority to the acceptance and treatment of pregnant women. In residential programs, if a bed is not available, the program must refer the individual to another Department of Mental Health certified program that does have the capacity to admit the individual. If residential treatment placement is not found, the individual must be assessed and referred, by the initial provider,

to another appropriate substance abuse service and to a local health care provider for prenatal care until appropriate residential treatment is identified. This process must be completed within 48 hours of the initial Intake/Assessment and documented by the initial service provider. Written documentation must be submitted to the DMH Division of Alcohol and Drug Abuse.

XVIII.A.8. ~~2700.7 Joint Commission on Accreditation of Health Care Organizations (JCAHO)~~ The Joint Commission (TJC) accredited substance abuse treatment service providers (not funded by DMH) seeking ~~Department of Mental Health (DMH)~~ DMH certification must submit documentation of ~~JCAHO~~ TJC accreditation in the specific substance abuse area(s) that corresponds (not to include DUI) with the substance abuse service area(s)included in the DMH ~~Minimum Standards for Community Mental Health/Mental Health Services, Part VII - Alcohol and Drug Services.~~ Operational Standards Part VII, Section B and Part XVIII. The DMH will determine if the documentation is sufficient to support certification in the specific substance abuse services areas.

XVIII.A.9. DUI must be a separate accreditation from The Joint Commission.

XVIII.A.10. Intensive Outpatient Programs (IOP) must be limited to twelve (12) individuals per session.

XVIII.A.11. Caseloads for primary residential program staff must be no more than eight (8).

XVIII.A.12. ~~2700.8~~ 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.

XVIII.A.13. ~~2700.9~~ All programs must have a physical environment which provides designated space for privacy of individual and group counseling sessions.

SECTION B - DETOXIFICATION SERVICES

XVIII.B.1. Detoxification is the process through which a person who is physically and/or psychologically dependant on alcohol, illegal drugs, prescription medications, or a combination of these drugs is withdrawn from the drug or drugs of dependence. Methods of detoxification include: medical detoxification, which is detoxification in a hospital

setting, and social detoxification which is detoxification in a non-hospital supportive environment.

XVIII.B.2. The expected outcomes for Detoxification Services include:

a. Individuals are provided medical or social detoxification services.
b. Individuals are successfully and safely withdrawn from their drug or drugs of dependence.

XVIII.B.3. ~~2800.0~~ Primary residential programs providing detoxification services must have written policies and procedures which specify the following:

a. An individual designated as responsible for coordinating detoxification services.

b. A description of the method by which detoxification services are offered.

c. A description of the method by which referrals are made to physicians and/or hospitals for appropriate medical intervention.

XVIII.B.4. ~~2800.1~~ Following social detoxification under a physician's supervision, ~~Primary residential programs must have written policies and procedures which describe the monitoring/observation, when prescribed by a physician, by~~ program personnel must do a bed check of each individual ~~of individuals~~ for signs or symptoms of psychological or physical withdrawal at least every hour for the first 24 hour period after admission; followed by a reduction to at least every two (2) hours for the following 24 hour period and, as needed, thereafter.

XVIII.B.5. ~~2800.2~~ Primary residential detoxification programs must have:

a. A licensed physician on staff or available on a 24 hour basis through affiliation agreement/contract, who has admitting privileges at a local hospital; or

b. A written agreement or contract with a local hospital to provide inpatient detoxification services, including emergency services.

XVIII.B.6. ~~2800.3~~ Primary residential detoxification programs must have a written plan describing the handling of medical emergencies which includes the roles of staff members and physicians.

~~SECTION C - PRIMARY RESIDENTIAL SERVICES~~

XI.J.20. The primary residential substance abuse treatment program is an intensive residential program for individuals who are addicted to or abuse alcohol/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. Because alcohol and drug dependency is 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.

XI.J.26. ~~2900.0~~ The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling with each individual;

c. Family counseling;

d. At least ~~ten (10)~~ 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;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational counseling and planning/referral for follow-up vocational services.

g. For ~~adolescents~~ children/youth, the academic schedule indicating school hours.

~~2900.1 The program must provide 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 where appropriate.~~

~~In addition, Special Residential Treatment Programs Serving Pregnant and Parenting Women with Young Children Who Reside on the Program Site must also meet the following:~~

~~2910.0 All programs must provide for adequate, secure, and supervised play space for the children of women served in the program.~~

~~2910.1 Each school-age child must be enrolled in and attend an appropriate educational program in the local school district or be enrolled in an educational program operated by the service provider that meets the individualized educational needs of the child and is accredited by the Mississippi Department of Education.~~

~~2910.2 All programs must prohibit the use of any form of corporal punishment. Staff must provide residents with information regarding positive approaches to management of children's behavior.~~

~~In addition, Residential Treatment Programs for Adolescents must also meet the following:~~

~~2920.0 All programs must complete the DMH Intake/Assessment for each individual including the Substance Abuse and Children & Youth Specific Intake/Assessment.~~

~~2920.1 Each adolescent must be enrolled in and attend an appropriate educational program in the local school district or be enrolled in an educational program operated by the service provider that meets the individualized educational needs of the adolescent and is accredited by the Mississippi Department of Education.~~

~~2920.2 Programs serving adolescents must have the following:~~

~~a. A full-time director with the qualifications listed in Part II-Organization and Management, Section B-Personnel Policies, Standard 20.5 o.~~

~~b. A clinical coordinator with the qualifications listed in Part II-Organization and Management, Section B-Personnel Policies, Standard 20.5 q.~~

XI.J.24. ~~2920.3~~ Programs must have accessibility either through program staff or affiliation agreement/contract to the following:

a. A licensed psychiatrist with experience in the treatment of substance abuse/addiction; or,

b. A licensed psychologist with experience in the treatment of substance abuse/addiction; and

c. A licensed physician with experience in the treatment of substance abuse/addiction.

~~2920.4 The program must obtain a permission form for the individual to participate in specific program activities off the program site which must be signed by the parent or legal guardian.~~

~~2920.5 The program must obtain a permission form for staff to provide first aid or other emergency medical attention which must be signed by the parent or legal guardian.~~

~~2920.6 The residential facility must be equipped with an operable security system that has the capacity to monitor unauthorized entrance or exit from the facility.~~

~~2920.7 All residential programs serving adolescents must also comply with the following Minimum Standards specified in Part VI-Children and Youth Services, Section A-General Standards and Section B-Residential Services for Children and Youth, Therapeutic Group Homes (TGH).~~

~~a. 1500.9*;~~

~~b. 1501.0;~~

~~c. 1610.2;~~

~~d. 1610.3; and,~~

~~e. 1610.8 as follows: The provider must ensure that an adequate number of professional staff are available and on-site and are qualified by training and experience to provide programmatic direction and supervision. The staffing composition pattern will be subject to approval by the Department of Mental Health, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of youth served.~~

~~2920.8 All residential programs serving adolescents with a dual diagnosis of serious emotional disturbance and substance abuse must also comply with the following Minimum Standards specified in Part VI-Children and Youth Services, Section A-General Standards and Section B-Residential Services for Children and Youth, Therapeutic Group Homes (TGH):~~

~~a. 1500.1 f.;~~

~~b. 1500.2;~~

~~c. 1501.2; and,~~

~~d. 1600.0.~~

~~SECTION D - TRANSITIONAL RESIDENTIAL SERVICES~~

XI.I.16. The transitional living residential substance abuse treatment program ~~focuses on the enhancement of social skills needed to lead a productive, fulfilling life in the community. The program~~ provides a group living environment, which promotes a life free from chemical dependency, while encouraging the pursuit of vocational, employment or related opportunities. With group support, individuals acquire coping skills which enable them to become productive citizens in their communities. ~~An individual must have successfully completed a primary substance abuse treatment program before being eligible for admission. The primary substance abuse treatment program must be of a duration that consists of longer than what would be considered a hospital or social detoxification period.~~

XI.I.20. ~~3000.0~~ The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling which accommodates individual employment schedules;

c. Family counseling;

d. 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;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational, educational, employment, or related activities.

~~3000.1 The program must provide 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 where appropriate.~~

~~In addition, Special Residential Treatment Programs Serving Pregnant and Parenting Women with Young Children Who Reside on the Program the Site must also comply with the following:~~

~~3010.0 All programs must provide for adequate, secure, and supervised play space for the children of women served in the program.~~

~~3010.1 Each school-age child must be enrolled in and attend an appropriate educational program in the local school district or be enrolled in an educational program operated by the service provider that meets the individualized educational needs of the child and is accredited by the Mississippi Department of Education.~~

~~3010.2 All programs must prohibit the use of any form of corporal punishment. Staff must provide residents with information regarding positive approaches to management of children's behavior.~~

SECTION ~~E~~ C- OUTREACH/AFTERCARE SERVICES

XVIII.C.1. Outreach services provide information on, encourage utilization of, and provide access to needed treatment or support services in the community to assist persons with alcohol/drug problems and/or their families. Aftercare services are designed to assist individuals who have completed primary substance abuse treatment in maintaining sobriety and achieving positive vocational, family, and personal adjustment. Aftercare also offers the individual with structured support and assistance which may include securing additional needed services from community mental health centers or from other health/human service providers and maintaining contact and involvement with the individual's family.

XVIII.C.2. The expected outcomes for Outreach/Aftercare Services include:

a. Individuals receive needed assistance finding access to substance abuse treatment and other support services in the community.

b. Individuals receive Aftercare Services in order to maintain sobriety.

XVIII.C.3. ~~3100.0~~ The program must establish and implement written policies and procedures and documentation that the following outreach/aftercare services are available to adults:

a. Structured and organized group meetings with outreach/aftercare worker a minimum of one (1) hour per week on a consistent basis;

b. Individual sessions with outreach/aftercare worker, as needed;

c. Family sessions with outreach/aftercare worker, as needed;

d. Employer contacts, as needed;

e. Referrals and linkage with additional needed services.

XVIII.C.4. ~~3100.1~~ Outreach/aftercare staff must make at least one (1) attempt to contact each member per month. Group or individual sessions are acceptable as contacts.

XVIII.C.5. ~~3100.2~~ The outreach/aftercare worker must maintain on site a comprehensive file of existing community resources. Each listed resource must include:

a. The name, location, telephone number and hours of operation of the resource;

b. The types of services provided by the resource;

c. Eligibility requirements;

d. Contact person(s).

XVIII.C.6. ~~3100.3~~ The outreach/aftercare worker must conduct community outreach activities to educate their community about substance abuse treatment and prevention services offered through their organization. Documentation of these activities must be kept in a log listing a brief description of the audience receiving the outreach contact/activity, type of contact/activity, date, and number of participants.

XVIII.C.7. Aftercare Services must be provided to individuals in their respective catchment areas regardless of where the Primary Treatment Services have been completed.

SECTION ~~F~~ D- PREVENTION SERVICES

XVIII.D.1. 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 and related problem behaviors to provide immediate and long-term positive results.

XVIII.D.2. The expected outcomes for Prevention Services include:

a. Individuals experience a reduction in risk factors linked to Alcohol, Tobacco and Other Drugs (ATOD).

b. Individuals experience an increase in protective factors linked to ATOD.

c. Evidence based curricula are being utilized.

XVIII.D.3. ~~3200.0~~ 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. Strategies a.-c. have specific requirements described in subsequent standards.

a. Information/dissemination;

b. Affective education programs;

c. Alternative programs;

d. Problem/Identification and referral;

e. Community-based process (Community development);

f. Environmental programs.

XVIII.D.4. ~~3200.1~~ All providers of prevention services must document all prevention activities on the designated Internet-based tool or other required tool by the 10th working day of the month following the reporting period.

XVIII.D.5. ~~3200.2~~ ~~The prevention program~~ All prevention providers must have ~~documentation of~~ a staff member designated to coordinate the

prevention program. This is in accordance with RFP guidelines and contracts.

~~3200.3 Prevention programs utilizing the Information/dissemination strategy must maintain records which document that the information and/or training presented was alcohol/tobacco/drug specific and was conducted for a minimum time period of one (1) hour.~~

~~3200.4 Prevention programs utilizing the Affective education strategy must maintain records that document:~~

~~a. Presentations for primary groups (grade K-college) contain no more than thirty-five (35) individuals and are conducted for a minimum combined time period of (3) three hours. (May consist of more than one session.)~~

~~b. Presentations for secondary groups (parents, teachers, etc.) are conducted for a minimum time period of at least one (1) hour.~~

~~3200.5 Prevention programs utilizing the~~ Alternative program ~~strategy must maintain records that document the~~ specific alternatives ~~to the use of alcohol/tobacco/drugs included in each presentation.~~

XVIII.D.6. ~~3200.6~~ All prevention programs must show evidence of ongoing use of at least one (1) model, ~~science~~ evidence-based curriculum recommended by the Center for Substance Abuse Prevention (CSAP). The percentage of implementation to an evidence-based curriculum must adhere to BADA grant requirements.

~~3200.7 Documentation must be available on site providing descriptions of the activities recorded on the Internet-based tool designated by the Division of Alcohol and Drug Abuse, which, at a minimum, include:~~

~~a. Contact person requesting services;~~

~~b. Curriculum used, if any;~~

~~c. Topics addressed;~~

~~d. Detailed description of activity;~~

~~e. Amount of time spent, delineated by planning, travel, and direct service activity.~~

XVIII.D.7. ~~3200.8~~ No prevention services will be provided to persons who are actively engaged in any alcohol and drug abuse treatment program on a continuous basis or as part of an ongoing program.

XVIII.D.8. ~~3200.9 All persons providing prevention services~~ Individuals working in prevention services must have their own working computer (provided by the agency) with Internet ~~convenient, continuous~~ access to the Internet in order to keep abreast of the most current model, ~~science~~ evidence-based prevention technology.

~~SECTION G - CHEMICAL DEPENDENCY UNIT SERVICES~~

XI.J.15. Chemical Dependency Unit Services include inpatient or hospital-based ~~facilities offer~~ services for individuals with more severe alcohol and/or drug abuse problems and who require a medically-based environment. Treatment usually includes detoxification, group, individual, and family therapy; education services explaining alcohol/drug dependency, personal growth, and the recovery process, aftercare, and family counseling.

~~3300.0 The program must meet the licensure and certification requirements of the appropriate responsible agency, as required by state law.~~

~~3300.1 The program must be staffed 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 where appropriate.~~

XI.J.19. ~~3300.2~~ The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour of individual counseling per week with each individual;

b. At least five (5) hours per week of group counseling with each individual;

c. Family counseling;

d. At least ten (10) hours per week of education services dealing with substance abuse and addiction, self-help/personal growth, social skills, anger management, and recovery process, and a philosophy of living which will support recovery;

e. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval);

f. Vocational counseling and planning/referral for follow-up vocational services.

g. For adolescents, the academic schedule indicating school hours.

~~In addition, Inpatient CDU Programs for Adolescents must also comply with the following:~~

~~3310.0 All programs must complete the DMH Intake/Assessment for each individual, including the Substance Abuse and Children & Youth Specific Intake/Assessment.~~

~~3310.1 Each adolescent must be enrolled in and attend an appropriate educational program in the local school district or be enrolled in an educational program operated by the service provider that meets the individualized educational needs of the adolescent and is accredited by the Mississippi Department of Education.~~

~~3310.2 The program must obtain a permission form for the individual to participate in specific program activities off the program site which must be signed by the parent or legal guardian.~~

~~3310.3 The program must obtain a permission form for staff to provide first aid or other emergency medical attention which must be signed by the parent or legal guardian.~~

~~3310.4 The program facility must be equipped with an operable security system that has the capacity to monitor unauthorized entrance or exit from the facility.~~

~~3310.5 Programs serving adolescents must have the following:~~

~~a. A full-time director with the qualifications listed in Part II-Organization and Management, Section B-Personnel Policies, Standard 20.5 o.~~

~~b. A clinical coordinator with the qualifications listed in Part II-Organization and Management, Section B-Personnel Policies, Standard 20.5 q.~~

3310.6 All programs serving adolescents must also comply with the following Minimum Standards specified in Part VI-Children and Youth Services, Section A-General Standards and Section B-Residential Services for Children and Youth, Therapeutic Group Homes (TGH):

a. 1500.9*;

b. 1501.0;

c. 1610.2;

d. 1610.3; and,

e. 1610.8 as follows: The provider must ensure that an adequate number of professional staff are available and on-site and are qualified by training and experience to provide programmatic direction and supervision. The staffing composition pattern will be subject to approval by the Department of Mental Health, depending on the age, developmental or functional level, or intensity of need for intervention and supervision of the population of youth served.

3310.7 All programs serving adolescents with a dual diagnosis of serious emotional disturbance and substance abuse must also comply with the following Minimum Standards specified in Part VI-Children and Youth Services, Section A-General Standards.

a. 1500.2; and

b. 1501.2.

d. 1600.0.

SECTION H - OUTPATIENT SERVICES

General outpatient substance abuse treatment is appropriate for individuals whose clinical condition or environment circumstances do not require a more intensive level of care. Multiple treatment modalities, techniques and strategies include individual, group, and family counseling.

3400.0 The outpatient program must provide the following services:

a. Individual therapy/counseling;

~~b. Group therapy/counseling;~~

~~c. Family therapy/counseling.~~

~~Intensive Outpatient Program (IOP)~~

~~The 10-Week Intensive Outpatient Program (IOP) is a community-based outpatient program which provides an alternative to traditional residential treatment or hospital settings. The program is directed to persons who need services more intensive than traditional outpatient services, but who have less severe alcohol and drug problems than those typically addressed in residential treatment. The IOP allows individuals to continue to fulfill his/her obligations to family, job, and community while obtaining intensive treatment.~~

~~3410.0 Intensive Outpatient Programs must provide the following services:~~

~~a. Group lecture or therapy for a minimum of three (3) nights a week for three (3) hours each night for at least ten (10) weeks;~~

~~b. Individual therapy at a minimum of one (1) counseling session per week;~~

~~c. Involvement of family or significant others as necessary to meet needs of the individual.~~

~~3410.1 Each full time staff member assigned to the Intensive Outpatient Program must maintain an active caseload of two (2) to twelve (12) individuals.~~

SECTION ~~I~~ E- DUI DIAGNOSTIC ASSESSMENT SERVICES FOR SECOND AND SUBSEQUENT OFFENDERS

XVIII.E.1. The DUI diagnostic assessment is a process by which a diagnostic instrument (such as Mortimer-Filkins, Substance Abuse Subtle Screening Inventory (SASSI), or other DMH approved instrument) is administered and the result is combined with other required information to determine the offenders appropriate treatment environment.

XVIII.E.2. The expected outcome for DUI Diagnostic Assessment Services is that individuals who are eligible for the DUI Track, are given an approved diagnostic assessment prior to substance abuse treatment to determine the most appropriate type of treatment modality.

XVIII.E.3. ~~3500.0~~ All ~~programs certified by the Department of Mental Health to~~ DMH certified programs which conduct DUI Assessments must have a designated staff member(s) responsible, accountable, and trained to administer the assessment and ~~complete~~ implement the program procedures.

XVIII.E.4. ~~3500.1~~ The program must have written policies and procedures and adhere to those policies and procedures which describe:

a. ~~How the diagnostic assessment (components listed in following standard) is administered and evaluated prior to treatment in order to determine the most appropriate type of substance abuse treatment for the individual.~~ Addressing DUI assessments for individuals completing primary treatment from non-DMH certified treatment programs.

b. The criteria by which the treatment environment is determined.

c. The criteria by which successful completion of treatment is determined for DUI offenders.

d. The process by which an individual is admitted into a substance abuse treatment program following completion of the DUI diagnostic assessment.

XVIII.E.5. The DUI diagnostic assessment (see components in Standard XVIII.E.6) must be administered and evaluated prior to treatment.

XVIII.E.6. ~~3500.2~~ A DUI diagnostic assessment must consist of the following components and documented in the individual's case file;

a. ~~The Department of Mental Health Intake/Assessment;~~ 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.

~~b. Motor Vehicle Report from the Department of Public Safety (or evidence of a written request);~~

~~c.~~ b. Results & interpretation of ~~an approved diagnostic instrument such as the Mortimer-Filkins,~~ the SASSI, or other DMH Bureau of Alcohol and Drug Abuse approved ~~instrument~~ tool. ~~Approval~~

~~must be obtained in writing from the Division of Alcohol and Drug Abuse. If the SASSI is utilized,~~ If certification is required, at least one staff member must be certified to administer this diagnostic tool.

XVIII.E.7. ~~3500.3~~ Individuals receiving DUI assessment/treatment services through a Specific DUI Outpatient Program Track must receive a minimum of twenty (20) hours of direct service (individual and/or group therapy), or as otherwise specified by the DMH ~~Division~~ Bureau of Alcohol and Drug Abuse, before receiving the DMH Certification of DUI In-Depth Diagnostic Assessment and Treatment Form. Documentation of treatment will be maintained in the individual's case record.

XVIII.E.8. ~~3500.4~~ 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 ~~Division~~ Bureau of Alcohol and Drug Abuse when an individual has successfully completed the treatment program within ten (10) working days.

XVIII.E.9. ~~3500.5~~ All DUI Diagnostic Assessment services must be equipped to provide each individual the type of substance abuse treatment indicated by the results and interpretation of the assessment (components listed in this section above). Substance abuse treatment may be offered through the assessment service and/or through an affiliation agreement with a DMH certified substance abuse treatment program. The assessment service must be able to provide, at a minimum, outpatient and primary residential or inpatient chemical dependency substance abuse treatment.

~~PART VIII~~

~~COMMUNITY MENTAL HEALTH SERVICES FOR ADULTS~~

SECTION A – GENERAL STANDARDS

Standards contained in this section apply to mental health services for adults certified by the Bureau of Mental Health/Division of Community Services. The providers of such services must meet standards in Part I – Procedures for Certification, Part II – Organization and Management, Part III - Human Services, and Part V - Bureau of Mental Health General Standards, Part VIII – Adult Community Mental Health Services, and applicable sections of Part X – Other Community Services for Individuals with Mental Illness, Mental Retardation/ Developmental Disabilities, or Substance Abuse.

3600.0 The written policy and procedure manual must describe the placement of individual services for which the provider is certified within the agency's organizational structure.

3600.1 Written policies and procedures must address admission to services and must at a minimum:

a. Describe the process for admission or readmission to service(s);

b. Define the criteria for admission or readmission to service(s), including:

(1) Description of the population to be served (age(s), eligibility criteria, any special populations, etc.);

(2) Process for determination of eligibility for adult service(s) offered by the provider.

c. Describe the process or requirements for collecting intake/assessment information including the process for requesting appropriate consent to obtain relevant records from other providers.

d. Describe written materials provided to adults upon admission, including materials that may be included in an orientation packet, etc.

e. Describe the process for informing individuals of their rights and responsibilities (including any applicable program rules for residential programs) prior to or at the time of admission.

f. Describe the process to be followed when an individual is found ineligible for admission or readmission to service(s) offered by the provider, including referral to other agencies and follow-up, as

~~appropriate. Such referral(s) and follow-up contacts must be documented.~~

~~g. Describe procedures for maintaining and addressing a waiting list for admission or readmission to service(s) available to adults by the provider.~~

~~3600.2 All of the following information must be documented to support an eligibility determination of serious mental illness:~~

~~a. An individual who meets the criteria for one of the eligible diagnostic categories defined in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) or subsequent editions.~~

~~b. Adults, age 18 and over, with serious mental illness.~~

~~c. 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 Department of Mental Health.~~

~~3600.3 All providers must have an overall schedule available to individuals (and their families, if appropriate) for each service for which they are certified, which includes, at a minimum:~~

~~a. Hours of daily operation/hours service is available;~~

~~b. Number of days per year the service will be provided/be available; and,~~

~~c. Scheduled dates of closure/unavailability and reasons.~~

~~3600.4* Emergency telephone numbers must be posted in a conspicuous location near each telephone in each day and residential program site. Numbers must be included for:~~

~~a. Family member(s) or other contact (if appropriate and consent is on file);~~

~~b. Case manager(s) and therapist for individual;~~

~~c. Police;~~

~~d. Fire department;~~

~~e. Poison control center; and,~~

~~f. Ambulance/emergency medical services (EMS).~~

~~3600.5* Written policies and procedures must address all staff's responsibilities and roles in protecting the rights of the individual served by the provider as described in Part III, Section C – Rights of Individuals Receiving Services.~~

~~3600.6 Program activities must be designed to address objectives in individualized treatment plans. Treatment plan objectives must reflect individual strengths and needs of individuals and/or families/guardians (as appropriate) served by the program as reflected by intake/assessments and/or progress notes.~~

~~3600.7 Individualized treatment plans must address and/or be revised to address strengths and needs of the individual.~~

~~3600.8 Those service providers designated as DMH/C must support Consumer and Family Education programs.~~

PART XIII

ADULT MENTAL HEALTH SERVICES

All sections contained in this part pertain specifically to services and supports that are available to adults with serious mental illness.

SECTION A- PROGRAMS OF ASSERTIVE COMMUNITY TREATMENT (PACT)

XIII.A.1. Programs of Assertive Community Treatment (ACT) are 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.

XIII.A.2. Expected outcomes for PACT Services include:

e. Individuals receiving PACT Services will have decreased reliance on inpatient treatment.

f. Individuals who are hospitalized will have longer periods of time between hospitalizations.

g. Individuals receiving PACT services are satisfied with the services they receive that allow them to remain in the community while aiding in their recovery.

XIII.A.3. The important characteristics of programs of assertive community treatment are:

f. PACT serve 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.

g. PACT services are delivered by a group of multidisciplinary mental health staff (as defined in Standard XIII.A.6) 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.

h. 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.

i. PACT services are mobile and delivered 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.

j. 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 recompensate, consolidate gains, sometimes slip back, and then take the next steps forward until they achieve recovery**.**

Staffing

XIII.A.4. 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 10 (10) individuals (this ratio does not include the psychiatrist or psychiatric nurse

practitioner and the program assistant) .

XIII.A.5. 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.

XIII.A.6. In addition to meeting the qualifications outlined in Part VI, the following positions are required for PACT Teams:

a. 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.

b. 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.

c. At least two (2) Full-time registered nurses. A team leader with a nursing degree cannot replace one of the FTE nurses.

d. At least one (1) Master's level or above mental health professionals (in addition to the team leader).

e. At least one (1) Substance Abuse Specialist.

f. At least one (1) Employment Specialist

g. At least one (1) FTE certified peer specialist. Peer specialists must be fully integrated team members.

h. 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 paraprofessional 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-services 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. 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.

XIII.A.7. 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 (not including the psychiatrist or psychiatric nurse practitioner and the program assistant).

XIII.A.8. 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.

Admission and Discharge Criteria

XIII.A.9 In order to be admitted into PACT services, individuals must meet the criteria outlined in Standards XIII.A.10 through XIII.A.12 below.

XIII.A.10 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.)

XIII.A.11. Individuals with significant functional impairments as demonstrated by at least one of the following conditions:

a. 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.

b. 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).

c. Significant difficulty maintaining a safe living situation (e.g., repeated evictions or loss of housing).

XIII.A.12. 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):

a. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services.

b. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).

c. Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months).

d. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration).

e. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or in imminent risk of becoming homeless.

f. 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.

g. Difficulty effectively utilizing traditional office-based outpatient services.

XIII.A.13. Discharges from PACT Services occur when individuals and program staff mutually agree to the termination of services. This must occur when individuals:

a. Have successfully reached individually established goals for discharge, and when the individual and program staff mutually agree to the termination of services.

b. 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.

c. 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.

d. Decline or refuse services and request discharge, despite the team's best efforts to develop an acceptable Individual Service Plan with the individual.

Frequency of Individual Contact

XIII.A.14. 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 times per day, seven 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.

XIII.A.15. 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.

XIII.A.16. The PACT team must provide a mean (i.e., average) of at least three (3) contacts per week for all individuals.

XIII.A.17. Each new PACT team must gradually build up its case load with a maximum admission rate of five (5) individuals per month.

Hours of Operation and Staff Coverage

XIII.A.18. The PACT team must be available to provide treatment, rehabilitation, and support activities seven days per week. When a team does not have sufficient staff numbers to operate two 8-hour shifts weekdays and one 8-hour shift weekend days and holidays, staff are regularly scheduled to provide the necessary services on a individual-by-individual basis (per the individual-centered comprehensive assessment and individualized Individual Service Plan) in the evenings and on weekends. This includes:

a. Regularly scheduling staff to cover individual contacts in the evenings and on weekends.

b. Regularly scheduling mental health professionals for on-call duty to provide crisis and other services the hours when staff are not working.

c. 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.

h. 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).

e. If "c" or "d" occurs, memoranda of agreement or formal contracts should be established and kept on file by the provider.

Place of Treatment

XIII.A.19. Each PACT Team must set a goal of providing 85 percent of service contacts in the community in non-office-based or non-facility-based settings.

Staff Communication and Planning

XIII.A.20. 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:

a. The PACT team must maintain a written daily log. The daily log

provides:

(1) A roster of the individuals served in the program, and

(2) For each individual, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the individual's status that day.

b. 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.

c. 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.

d. 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.

e. 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.

f. 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.

XIII.A.21. 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:

a. Convene at regularly scheduled times per a written schedule set by the team leader.

b. 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.

c. Require individual staff members to present and systematically review and integrate individual information into a holistic analysis and prioritization of issues.

d. Occur with sufficient frequency and duration to make it possible for all staff:

(1) to be familiar with each individual and their goals and aspirations;
(2) to participate in the ongoing assessment and reformulation of issues/problems;
(3) to problem-solve treatment strategies and rehabilitation options;
(4) to participate with the individual and the Individual Treatment Team in the development and the revision of the Individual Service Plan; and
(5) to fully understand the Individual Service Plan rationale in order to carry out each individual's plan.

Staff Supervision

XIII.A.22. 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:

h. 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;

i. 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;

j. Regular meetings with individual staff to review their work with individuals, assess clinical performance, and give feedback;

k. Regular reviews, critiques, and feedback of staff documentation (i.e., progress notes, assessments, Individual Service Plans, Individual Service Plan reviews); and

l. Written documentation of all clinical supervision provided to PACT team staff.

Required Services

XIII.A.23. 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 (a-k):

a. Service Coordination/Individual Treatment Team

(1) 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.

(2) Each individual will be assigned to Individual Treatment Team (ITT.) The ITT is a group or combination of three (3) to five (5) ACT 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.

b. Crisis Assessment and Intervention

(1) 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 (see Part VIII, Section A) program as appropriate.
(2) A system must be in place that assures the individual can contact the PACT as necessary.

d. Symptom Assessment and Management

This must include, but is not limited to, the following:

(7) Ongoing comprehensive assessment of the individual's mental illness symptoms, accurate diagnosis, and the individual's response to treatment.

(8) Psycho-education regarding mental illness and the effects and side effects of prescribed medications.

(9) 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.

(10) Individual supportive therapy.

(11) Psychotherapy.

(12) 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.

d. Medication Prescription, Administration, Monitoring and Documentation

(1) The PACT team psychiatrist/psychiatric nurse practitioner must:

a. Establish an individual clinical relationship with each individual.

b. Assess each individual's mental illness symptoms and provide verbal and written information about mental illness.

c. Make an accurate diagnosis based on the comprehensive assessment which dictates an evidence-based medication pathway that the psychiatrist/psychiatric nurse practitioner will follow.

d. Provide education about medication, benefits and risks, and obtain informed consent.

e. Assess and document the individual's mental illness symptoms and behavior in response to medication and must monitor and document medication side effects.

f. Provide psychotherapy.

(2) 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.

(3) The PACT team program must establish medication policies and procedures which identify processes to:

a. Record physician orders.

b. Order medication.

c. Arrange for all individual medications to be organized by the team and integrated into individuals' weekly schedules and daily staff assignment schedules.

d. 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.

e. Administer medications per state law to individuals receiving PACT services.

f. Comply with Part IV, Section J.

e. Dual Diagnosis Substance Abuse Services

(1) Dual Diagnosis 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:

(f) Engagement (e.g., empathy, reflective listening, avoiding argumentation).

(g) Assessment (e.g., stage of readiness to change, individual-determined problem identification).

(h) Motivational enhancement (e.g., developing discrepancies, psycho-education).

(i) Active treatment (e.g., cognitive skills training, community reinforcement).

(j) Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).

f. Work-Related Services

(1) 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:

(g) 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.

(h) 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.

(i) Development of an ongoing employment plan to help each individual establish the skills necessary to find and maintain a job.

(j) Individual supportive therapy to assist individuals to identify and cope with mental illness symptoms that may interfere with their work performance.

(k) On-the-job or work-related crisis intervention.

(l) Work-related supportive services, such as assistance with grooming and personal hygiene, securing of appropriate clothing, wake-up calls, and transportation, if needed.

g. Activities of Daily Living

(1) 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:

(g) 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).

(h) Perform household activities, including house cleaning, cooking, grocery shopping, and laundry.

(i) Carry out personal hygiene and grooming tasks, as needed.

(j) Develop or improve money-management skills.

(k) Use available transportation.

(l) Have and effectively use a personal physician and dentist.

h. Social/Interpersonal Relationship and Leisure-Time Skill Training

(1) 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:

(f) Improve communication skills, develop assertiveness, and increase self-esteem.

(g) Develop social skills, increase social experiences, and develop meaningful personal relationships.

(h) Plan appropriate and productive use of leisure time.

(i) Relate to landlords, neighbors, and others effectively.

e. Familiarize themselves with available social and recreational opportunities and increase their use of such opportunities.

i. Peer Support Services

(1) 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:

(c) Peer counseling and support.

(d) Introduction and referral to consumer self-help programs and advocacy organizations that promote recovery.

j. Support Services

(1) Support services or direct assistance to ensure that individuals obtain the basic necessities of daily life, including but not necessarily limited to:

(g) Medical and dental services.

(h) Safe, clean, affordable housing.

(i) Financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance).

(j) Social services.

(k) Transportation.

(l) Legal advocacy and representation.

k. Education, Support, and Consultation to Individuals' Families and Other Major Supports

(1) Services provided regularly under this category to individuals' families and other major supports, with individual agreement or consent, include:

a. Individualized psycho-education about the individual's illness and the role of the family and other significant people in the

therapeutic process.

b. Intervention to restore contact, resolve conflict, and maintain relationships with family and or other significant people.

c. Ongoing communication and collaboration, face-to-face and by telephone, between the PACT team and the family.

d. Introduction and referral to family self-help programs and advocacy organizations that promote recovery.

e. Assistance to individuals with children (including individual supportive counseling, parenting training, and service coordination) including but not limited to:

(1) Services to help individuals throughout pregnancy and the birth of a child.

(2) Services to help individuals fulfill parenting responsibilities and coordinate services for the child/children.

(3) Services to help individuals restore relationships with children who are not in the individual's custody.

Stakeholder Advisory Groups

XIII.A.24. 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.

XIII.A.25. The stakeholder advisory group must:

a. Promote quality PACT model programs.

b. Monitor fidelity to the PACT program standards.

c. Guide and assist with the administering agency's oversight of the PACT program.

d. Problem-solve and advocate to reduce system barriers to PACT implementation.

e. Review and monitor individual and family grievances and complaints.

f. Promote and ensure individuals' empowerment and recovery values in assertive community treatment programs.

Program Requirements

XIII.A.26. 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.

SECTION B- CO-OCCURRING DISORDERS

XIII.B.1. Co-Occurring Disorders Services are provided to individuals who are affected by both a diagnosed mental illness and substance abuse disorder.

XIII.B.2. The expected outcome for Co-Occurring Services is that individuals with co-occurring disorders (mental illness and substance abuse) receive individualized services to meet their needs based on appropriate screening and assessment.

XIII.B.3. Providers must utilize the screening tool and assessment provided by the DMH.

SECTION C- DROP IN CENTER SERVICES

XIII.C.1. Drop In Center Services are a program 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.

XIII.C.2. Expected outcome for Drop In Center Services is that individuals will take control of their own recovery, focusing on building better lives.

XIII.C.3. Individuals receiving Drop in Center Services must meet eligibility requirements for one or more of the following service categories:

a. Adults who are determined to have a serious mental illness (SMI).

b. Individuals (adults) with a substance abuse diagnosis.

c. Chronically homeless

XIII.C.4. 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.

XIII.C.5. 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.

XIII.C.6. The program must have an annual average daily attendance of eight (8) individuals.

XIII.C.7. All program space must be accessible to both individuals and staff. There are to be no "staff-only" or "individual/member-only" spaces.

XIII.C.8. 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 by DMH.

XIII.C.9. Written policies and procedures, including a description of the program, must be maintained and must include, but not be limited to, the following:

a. The purpose, goals, and objectives of the program;

b. 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 a clubhouse or a work activity center, but still need structured daily activities;

c. The daily hours of operation and number of people to be served at each program site;

d. Description of the daily activities to be available;

e. Description of how to involve family members and significant others in supporting program participants;

f. Description of how the drop in center interacts with the traditional mental health center/programs;

g. Mechanisms to be used to establish members as decision makers in the operation of the service;

h. Description of how to develop and maintain consumer volunteers and employ consumers of mental health services; and

i. Description of homeless outreach activities.

XIII.C.10. The structured activities of the program must be designed to:

a. Maintain individuals in an environment less restrictive than inpatient or therapeutic residential treatment;

b. Develop daily living, social and other therapeutic skills;

c. Promote personal growth and enhance the self-image and/or improve or maintain the individual's abilities and skills;

d. Provide assistance in maintaining and learning new skills that promote independence;

e. Develop interpersonal relationships that are safe and wanted by the individual to eliminate isolation;

f. Improve physical and emotional well being; and,

(m) Promote empowerment and recovery.

XIII.C.11. The provider must have structured activities that include the following as appropriate for each individual:

a. Social skills training.

b. Group therapy.

c. Individual therapy.

d. Training on use of leisure time activities.

e. Coping skills training.

XIII.C.12. 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 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.

XIII.C.13. Staffing ratio must be at least one (1) staff member at all times for every twelve (12) individuals served by the program.

XIII.C.14. The designated program supervisor (see Standard VI.C.1(c)) must will 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.

XIII.C.15. Drop In Center programs must have a board or advisory council that it made up of fifty percent (50%) consumers of mental health services.

XIII.C.16. The program must maintain an evaluation system which addresses at a minimum:

a. Total number of members on roll;

b. Daily attendance;

c. Annual attendance by subgroups (age, sex, race); and

d. Reasons for leaving the program (i.e. recidivism vs. progression toward community integration).

SECTION B - PSYCHOSOCIAL REHABILITATION/CLUBHOUSE SERVICES

Psychosocial Rehabilitation/Clubhouse is a community support service for people with serious mental illness which consists of a network of services that help the service recipient develop the potential to live independently and/or become employed. Psychosocial rehabilitation/clubhouse is a program of structured activities designed to support and enhance the role functioning of individuals with serious and persistent mental illnesses who are able to live in their communities through the provision of regular, frequent environmental 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, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

3700.0 The program must operate in one location for a minimum of four (4) hours per day, four (4) days per week, excluding travel time.

3700.1 A Psychosocial Rehabilitation/Clubhouse program must have an annual average daily attendance of more than eight (8) members.

3700.2* All activities of the program must be established around a day which is structured by task activity units. The units provide all individuals/members an opportunity to participate.

3700.3* There must be a minimum of two (2) task activity units, which can include but not be limited to:

a. Clerical unit;

b. Kitchen unit;

c. Snack bar unit;

d. Gardening unit.

3700.4* Transitional and other employment opportunities must be an integral part of the Psychosocial Rehabilitation/Clubhouse service and must be made available to at least 10% of the number of participants the program is certified to serve. A minimum of one transitional employment placement must be available in a competitive employment setting in the community in which individuals without disabilities are also employed and that is not operated by the provider program.

~~3700.5 Recreational and/or social activities must not be conducted during the structured program hours.~~

~~3700.6 The program must have its own identity, including its own name.~~

~~3700.7 The program is to be located in its own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other programs. The clubhouse is to be designed to facilitate the work-ordered day and at the same time be attractive, adequate in size, and convey a sense of respect and dignity.~~

~~3700.8 All program space must be accessible to both members and staff. There are to be no "staff-only" or "member-only" spaces.~~

~~3700.9 The program site must have sufficient space to accommodate the full range of program activities and services and must provide at least fifty (50) square feet of multipurpose space for each member.~~

~~3701.0 The Psychosocial Rehabilitation/Clubhouse staff must be assigned full time to the clubhouse program to the exclusion of providing any other service.~~

~~3701.1 The Psychosocial Rehabilitation/Clubhouse staff must include at each site a full time director who plans, coordinates, and evaluates the psychosocial rehabilitation service.~~

~~3701.2 Psychosocial Rehabilitation/Clubhouse programs must maintain a minimum of one qualified staff member to each eight or fewer participants the program is certified to serve.~~

~~3701.3 There must be, on file, a written plan and a description of the service that must include but not be limited to the following:~~

~~a. The purpose, goals, and objectives;~~

~~b. The population to be served, including the number of persons to be served by location;~~

~~c. The physical environment surrounding the program, at each site;~~

~~d. Mechanisms to be used to establish members as decision makers in the operation of the service;~~

e. Plan for developing and maintaining transitional employment placements.

3701.4 The program must maintain an evaluation system which addresses at a minimum:

a. Total number of members on roll;

b. Daily attendance;

c. Annual attendance by subgroups (age, sex, race);

d. Average length of stay;

e. Reasons for leaving the program (recidivism vs. progression toward community integration);

f. Member satisfaction with psychosocial services;

g. The number and type of transitional employment jobs;

h. The number of persons participating in transitional employment;

i. The number of hours available in the transitional employment program by placement;

j. The number of hours worked and income earned by each individual participating in the transitional employment program;

k. Degree of member involvement in decision making.

3701.5 Participants must have a method defined by policy and procedures to communicate their desires to the director of the psychosocial/clubhouse and to the Executive Director of the program, and there must be documentation of such communication on site.

3701.6 The program must hold a current certificate from the Department of Mental Health that establishes the total number of individuals that can be served at each clubhouse site. The number of individuals that the service has been certified to serve cannot be exceeded.

3701.7 Members must have the opportunity to participate in all the work of the clubhouse, including orientation, outreach, training, hiring, and evaluation of staff, or documentation requirements.

SECTION ~~C~~ G- CONSULTATION AND EDUCATION SERVICES

XIII.G.1. Consultation and education services utilize staff skills and knowledge to promote, develop, and/or strengthen mental health service delivery in the area served.

XIII.G.2. Expected outcomes for Consultation and Education Services include:

c. Increased community awareness of mental health related issues.
d. Linkages are developed with schools, community groups and other social/human services agencies.

XIII.G.3. ~~3800.0~~ The provider of the consultation and education program must develop and implement a written plan to provide for consultation and education services. The plan must include a range of activities for:

a. Developing and coordinating effective mental health education, consultation, and public information programs;

b. Increasing the community awareness of mental health related issues.

XIII.G.4. ~~3800.1~~ The consultation and education service must be designed to specifically meet the needs of the target populations of:

a. Children and youth;

b. Elderly persons;

c. Individuals with serious mental illness;

d. Individuals with intellectual/developmental disabilities;

~~d.~~ e. Individuals with a dual diagnosis (MH/A&D);

~~e.~~ f. Individuals with a mental illness who are homeless;

g. Military families and the military community;

~~f.~~ h. Other populations defined by the center/program.

XIII.G.5. ~~3800.2~~ The program must develop linkages with other health and social agencies that serve the target populations.

SECTION D - EMERGENCY SERVICES

Emergency services are those services designated for immediate and intensive intervention in personal crisis situations. An emergency situation is defined as a situation in which an individual's mental health needs exceed the individual's resources, in the opinion of the mental health professional assessing the situation. A program must be able to triage and make appropriate clinical disposition decisions, including accessing inpatient services or less restrictive alternatives.

3900.0* All persons involved in the provision of emergency services who are not mental health professionals must be provided training in the handling of mental health emergencies.

3900.1 The program must annually document efforts to secure agreements with hospitals ensuring availability of emergency rooms that are accessible to individuals within a reasonable period of time. Agreements, at a minimum, must address:

a. Training of emergency room staff in handling mental health emergencies;

b. The mental health program's provision for face-to-face contact with a mental health professional;

c. The mental health program's involvement in providing consultation in the care of persons who are admitted to a hospital for medical treatment of suicide attempts or other psychiatric emergencies.

3900.2* The provider must insure that the opportunity for crisis telephone and face-to-face contact with a mental health professional is available twenty-four (24) hours a day/seven days a week.

3900.3 Emergency service availability must be publicized, including listings in the telephone directories for the areas served by the program.

3900.4* The twenty four (24) hour telephone service must:

a. Include provisions for collect calls and/or toll-free telephone line operation;

b. Assure that the caller does not have to make more than two (2) calls to reach an emergency worker;

c. Have a reporting system that, at a minimum, documents:

(1) Identification of the individual in crisis;

(2) Time of call;

(3) Presenting problem;

(4) Actions taken;

(5) Follow-up plan and disposition at termination of service, including referrals made;

(6) Name of staff member handling the call;

(7) Condition of individual at termination of the emergency call.

3900.5 The program must have written procedures for follow-up emergency contacts.

3900.6 The program must:

a. Maintain a daily log of emergency contacts;

b. Maintain a staff roster and 24 hour on-call schedule for addressing emergencies, including "after-hours" emergencies.

3900.7 The service must include documentation of notification and involvement of significant others, and when contact is deemed inappropriate, documentation indicating why notification was not made.

3900.8* There must be documentation of staff assigned to emergency services trained and knowledgeable in the policies and procedures required for pre-evaluation screening and civil commitment.

SECTION ~~E~~ D- INPATIENT REFERRAL SERVICES

XIII.D.1. All programs certified as DMH/C must provide access to inpatient services in the individual's locale when appropriate.

XIII.D.2. The expected outcomes for Inpatient Referral Services include:

a. Individuals will have an increased knowledge of inpatient treatment options.

b. Individuals will have decreased waiting times for inpatient services.

XIII.D.3. ~~4000.0~~ The provider must have written policies and procedures for referral to inpatient services in the community, should an individual require such services.

XIII.D.4. ~~4000.1~~ The provider must maintain a current written agreement with a licensed hospital(s) to provide/make available inpatient services, which, at a minimum, addresses:

a. Identification of the community mental health program's responsibility for the individual's care while the individual is in inpatient status;

b. Description of services that the hospitals will make available to individuals who are referred; and,

c. How hospital referral, admission and discharge processes are coordinated with emergency, pre-evaluation screening and civil commitment services, and aftercare services.

SECTION ~~F~~ E- PRE-EVALUATION SCREENING AND CIVIL COMMITMENT EXAMINATION SERVICES

XIII.E.1. Pre-evaluation screening and civil commitment examination ~~services~~ are two events which include screening, examinations, and other services to determine the need for civil commitment and/or other mental health services, including outpatient or inpatient commitment~~, and to assess, plan for, and link individuals with appropriate services~~. These services also include assessment and plans to link individuals with appropriate services.

XIII.E.2. The expected outcomes for pre-evaluation screening and civil commitment examination services include:

a. Individuals/families receive a determination on need for civil commitment and/or other available mental health services in a timely manner.

b. Individuals and families are treated with respect during the pre-evaluation screening process.

XIII.E.3. ~~4100.0~~ The provider program 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:

a. The system for conducting pre-evaluation screenings;

b. The system for conducting civil commitment examinations;

c. The system for handling court appearances;

d. The services that are offered for the family and/or significant others;

e. 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.

XIII.E.4. ~~4100.1*~~ The pre-evaluation screening must be conducted by qualified staff of a regional community mental health center, and

a. Be performed by:

(1) A certified licensed psychologist or physician; or

(2) Persons with a Master's degree in a mental health or related field who have received training and certification in pre-evaluation screening by ~~the Department of Mental Health~~ DMH; or,

(3) Registered nurses who have received training and certification in pre-evaluation screening by the ~~Department of Mental Health~~ DMH.

(4) Additionally, staff who meet requirements (2) and (3) above, have completed and provide documentation of:

(a) at least six months of experience working with individuals with serious mental illness or serious emotional disturbance and;

(b) at least two behavioral observations of pre-evaluation screenings performed by qualified staff.

b. Be performed in accordance with Mississippi civil commitment statutes.

c. Be documented on such forms and providing such information required by the civil commitment law and/or the ~~Department of Mental Health~~ DMH.

XIII.E.5. ~~4100.2*~~ If the civil commitment examination service is provided, the examination must:

a. Be performed by ~~a certified licensed psychologist and a licensed physician or~~ by two 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.

b. Be documented on such forms, providing information required by law or the ~~Department of Mental Health~~ DMH. Minimum documentation must include information in the individual case record of the commitment examination results and the official disposition following the examination;

c. Include the evaluation of the individual's social and environmental support systems; and,

d. Include, when possible, the development of a treatment and follow-up plan for the individual and the family and/or significant others.

SECTION F – DESIGNATED MENTAL HEALTH HOLDING FACILITIES

XIII.F.1. Designated mental health holding facilities (hereafter referred to as "holding facility") house 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 which the county contracts. DMH will conduct yearly on-site visits to each holding facility to ensure they are in compliance with the standards below.

XIII.F.2. The expected outcomes for Designated Mental Health Holding Facilities include:

a. Individuals receive physician's services and medications (if needed) in a timely manner while awaiting transportation to a treatment facility.

b. Staff receive training in how to appropriate work with and protect individuals who have a mental illness.

Policies & Procedures

XIII.F.3. Each holding facility must have a manual that includes the written policies and procedures for operating and maintaining the facility housing 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.

XIII.F.4. The policies and procedures must:

b. 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.

b. 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.

e. 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.

f. Describe how the policies and procedures are made available to the public.

Personnel Policies

XIII.F.5. 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, including employment history and experience;

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

c. A copy of college transcripts, high school diploma, and/or appropriate documents to verify that educational requirements of the job description are met;

d. Documentation of an annual performance evaluation.

e. A written job description that shall include, at a minimum:

(1) Job title;

(2) Responsibilities of the job;

(3) Skills, knowledge, training/education and experience required for the job.

f. 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.

g. 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.

Training and Staff Development

XIII.F.6. Supervisory and direct service staff who work with individuals housed 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.

XIII.F.7. Documentation of training of individual staff must be included in individual training/personnel records and must include:

f. Date of training
g. Name(s) of staff participating;
h. Topic(s) addressed;
i. Name(s) of presenter(s) and qualifications;
j. Contact hours (actual time spent in training).

XIII.F.8. 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:

l. First aid and life safety, including handling of emergencies such as choking, seizures, etc.;

m. Preventing, recognizing and reporting abuse/neglect, including provisions of the Vulnerable Adults Act, and the Mississippi Child Abuse Law;

n. Handling of accidents and roadside emergencies (for programs transporting only);

o. De-escalation techniques & crisis intervention, including appropriate use of seclusion and restraint and applicable state and federal regulations pertaining to such rights of individuals being housed in the facility;

p. 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;

q. Fire safety and disaster preparedness to include:

(1) Use of alarm system
(2) Notification of authorities who would be needed/require contact in an emergency;
(3) Actions to be taken in case of fire/disaster, and;
(4) Use of fire extinguishers;

r. Cardiopulmonary Resuscitation (CPR) training (every two years);

s. Recognizing and reporting serious incidents, including completion and submission of reports;

t. Universal precautions for containing the spread of contaminants;

u. Adverse medication reaction and medial response; and

v. Suicide precautions

Procedures for Admitting and Housing Individuals

XIII.F.9. Each facility shall have written procedures for admission of individuals who are being involuntarily civilly committed and awaiting transportation. These procedures shall include, but not be limited to, the following:

a. Determine that the individual is legally admitted for holding;
b. Make a complete search of the individual and his/her possessions;
c. Properly inventory and store individual's personal property;
d. Require any necessary personal hygiene activities (e.g., shower or hair care, if needed);
e. Issue clean, laundered clothing or appropriate garments (e.g., suicide risk reduction garments);
f. Issue allowable personal hygiene articles;
g. Perform health/medical screening;
h. Record basic personal data and information to be used for mail and visiting lists;
i. Provide a verbal orientation of the individual to the facility and **daily** routines.

Environment/Safety

XIII.F.10. If the designated mental health holding facility for civil commitment purposes is part of a correctional facility or jail, individuals awaiting transfer related to civil commitment proceedings (or just individuals detained as part of the civil commitment process) must be housed separately from pre-trial criminal offense detainees or inmates serving sentences.

XIII.F.11. Rooms used for housing individuals must be free from structures and/or fixtures that could be used by detainees to harm themselves.

XIII.F.12. 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.

Risk Assessment

XIII.F.13. The following to be conducted immediately upon arrival:

a. Suicide assessment (using a DMH approved screening instrument)
b. Violence risk assessment (using a DMH approved screening instrument)

XIII.F.14. If the risk level for any of these assessments is deemed "high," a twenty-four hour (24) hour follow-up assessment by nurse or physician is required.

XIII.F.15. If the risk level for suicide is deemed "high," immediate suicide prevention actions must be instituted.

Assessment and Clinical Management

XIII.F.16. Each holding facility shall have written procedures 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:

a. 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.
b. 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:

(1) Vital signs (at a minimum: body temperature, pulse/heart rate, respiratory rate, & blood pressure)
(2) Accu-Chek monitoring for persons with diabetes
(8) Medical/drug history
(9) Allergy history
(10) Psychiatric history (note: look at pre-evaluation form)

XIII.F.17. Clinical Management of the individual being held should include:

a. Within seventy-two (72) hours of admission, individuals should be assessed by a psychiatrist or a psychiatric nurse practitioner.

b. Twenty-four (24) hour crisis/on-call coverage by a physician or psychiatric nurse practitioner.

c. Availability of ordered pharmacologic agents within twenty-four (24) hours.

d. Timely administration of prescribed medication in accordance with the MS Nurse Practice Act.

e. Access to medical services for preexisting conditions that require ongoing medical attention (e.g. high blood pressure, diabetes, etc.)

f. 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 detoxification).

g. Availability of continuous assessment or monitoring for persons with mental illness or substance abuse considered by medical or psychiatric staff to be at high risk.

h. Training/certification of staff in prevention/management of aggressive behavior program.

i. Procedures for maintenance of clinical records, including:

(1) Documentation of information by professional staff across disciplines,
(2) Documentation of physician's orders
(3) Basic personal data and information that ensures rapid emergency contact, if needed.

Dignity of Individuals

XIII.F.18. 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:

a. Protection and advocacy services/information
(1) Disability Rights MS 601-968-0600
2) Dept. of Mental Health 877-357-0388

b. Chaplain services

c. Telephone contact
d. Visits with family members

~~SECTION G - OUTPATIENT THERAPY SERVICES~~

~~Outpatient therapy services include individual, family, group and multi-family group therapy.~~

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

~~Family Therapy is defined as psychotherapy that takes place between a mental health therapist and family members, with or without the presence of the individual receiving services. Family therapy may also include others (DHS staff, foster family members, etc.) with whom the individual lives or has a family-like relationship.~~

~~Group Therapy is defined as psychotherapy that takes place between a mental health therapist and at least two (2) but no 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.~~

~~Multi-Family Group Therapy is defined as psychotherapy that takes place between a mental health therapist and family members of at least two different service recipients, with or without the presence of the individuals receiving services, directed toward the reduction/resolution of identified mental health problems so that the individuals and/or their families may function more independently and competently in daily life.~~

~~4200.0 Service must be available and accessible at appropriate times and places to meet the needs of the population to be served. The program must establish a regular schedule, with a minimum of three (3) hours weekly for provision of outpatient services on evenings and/or weekends.~~

~~4200.1 The program must have a written plan for services that identifies the manner in which each of the following special target populations will be served:~~

~~a. Elderly persons;~~
~~b. Individuals with serious mental illness;~~

~~c. Individuals with a dual diagnosis (MH/A&D);~~

~~d. Persons discharged from inpatient care;~~

e. Individuals with mental illness who are homeless.

4200.2 There must be written policies and procedures for:

a. Admission;

b. Coordination with case management and/or other services in which the individual is enrolled;

c. Follow-up designed to minimize dropouts and maximize treatment compliance;

d. Therapist assignments;

e. Referral to other appropriate services as needed;

f. Discharge planning

4200.3* The provider must have implemented policies and procedures that ensure that, at a minimum, for individual(s) being discharged from inpatient care:

a. The individual is given an appointment with a mental health professional within two (2) weeks after referral;

b. The individual is given an appointment with a physician within four (4) weeks after referral;

c. The individual is evaluated for and/or enrolled in case management services within two (2) weeks after referral to community services;

d. Inpatient referral facilities have current contact office and phone number information so that aftercare appointments are made within the above required time frames; and,

e. Professional staff have been trained and are knowledgeable in the policies and procedures in a.-d. above.

4200.4* The program must implement written policies and procedures for providing appointments for individuals being discharged from inpatient care that:

a. Provide a phone number where contact can be made to arrange for an appointment;

b. Assure that only one call by the requesting person is needed to receive an appointment;

SECTION H - CASE MANAGEMENT SERVICES

Case Management is the provision and coordination of services that are an integral part of helping individuals access needed medical, social, educational, and other services in order to attain their highest level of independent functioning. Activities include individual identification, assessment, reassessment, service planning, referral, service delivery monitoring, and supportive counseling as well as outreach services designed to seek out and engage persons who are eligible for case management, including adults with serious mental illness.

4300.0 The following individuals with serious mental illness (as defined in 3600.2) must be evaluated for the need for case management and provided case management, if needed based on the evaluation, unless the service has been rejected in writing by the individual evaluated:

a. Adults who have a serious mental illness and who receive substantial public assistance. (Public assistance is defined as Medicaid.)

b. Adults with serious mental illness referred to the community mental health center after discharge from an inpatient psychiatric facility.

4300.1 Case management must be offered to individuals with serious mental illness described in 4300.0, at a minimum, every twelve (12) months, if the individual continues receiving any mental health service continually for twelve (12) months or longer, and refusals documented in writing.

4300.2 In addition to complying with the appropriate areas of the current Minimum Standards for Community Mental Health/Mental Retardation Services, a program must comply with special guidelines for case management issued by the Department of Mental Health for the operation of the case management program.

4300.3* Supervision and caseload requirements for Case Management Programs:

a. The program must have an established case management unit with a full-time case management supervisor;

b. Individuals receiving case management must be assigned a single, full-time case manager;

c. The options for assigning caseloads to case managers are as follows:

(1) Regular caseloads - maximum of forty (40) individuals;

(2) Combination caseload of regular and follow-along - maximum of sixty (60) individuals to be composed of not more than twenty (20) regular and forty (40) follow-along;

(3) Caseload of follow-along only - maximum of eighty (80) individuals.

d. A list of each case manager's caseload must be available for review.

e. Insure services are delivered in high (at least once a week); moderate (at least twice a month); low (at least once a month) intensity or follow-along based on individual needs, but not less than every three (3) months. The service plan must clearly state and justify the frequency of contact.

(See DMH Guidelines for Case Management for additional information regarding caseload assignments.)

4300.4 The program must maintain a current comprehensive file of community resources which includes, at a minimum:

a. Name of agency;

b. Eligibility requirements;

c. Contact person;

d. Services available;

e. Phone number of the resource agency.

4300.5 Individuals receiving case management services with whom no contact has been reported for twelve (12) months must be terminated from

~~the case management program after a documented effort has been made to contact the individual.~~

~~4300.6 The provider must develop an annual written plan for providing case management services that must include, at a minimum, the following areas:~~

~~a. Identification of the target population as established in case management guidelines;~~

~~b. Specific strategies to be used for outreach to the target population;~~

~~c. Formal and informal linkage and coordination efforts with appropriate services in the community, including referral process;~~

~~d. Monitoring and follow-up.~~

~~4300.7 The case management program must have implemented written policies and procedures assuring that individuals being discharged from inpatient psychiatric care are provided an evaluation to determine the need for case management services within two weeks of referral to community services.~~

~~4300.8 All Case Managers are required to participate in the Department of Mental Health sponsored orientation within six (6) months following their date of hire, as well as other staff development opportunities and meetings as required by the Department of Mental Health.~~

~~4300.9 The provider must develop written policies and procedures that assure that all reporting forms are completed and submitted as required by the Department of Mental Health and by service guidelines.~~

~~4301.0 The provider must have a system for involving the individual and family in case management services when appropriate.~~

~~SECTION I - HALFWAY HOUSE SERVICES~~

XI.I.22. Halfway house services for individuals with serious mental illness must provide a readjustment and transitional living facility for individuals discharged from a psychiatric hospital who have demonstrated mental, physical, social and emotional competency to function more independently in the community.~~, or~~ Halfway House Services may also be provided for individuals who need this service as an alternative to a more restrictive treatment setting.

~~4400.0 The provider of the halfway house program must have a written statement describing its philosophy, goals and objectives for treatment which includes:~~

~~a. The target population and geographic area served;~~

~~b. Number of residents to be served (program bed capacity); and,~~

~~c. Method of program evaluation.~~

XI.I.25. ~~4400.1*~~ The provider of the halfway house program must have a written plan of service delivery which includes:

~~a. Resident selection criteria;~~

~~b. Procedures for admission to the program;~~

~~c. Procedures for establishing and maintaining a waiting list;~~

d. A schedule of activities or procedures providing access to the following:

(1) At least one (1) hour of individual counseling or two (2) hours of group counseling per week;

(2) At least four (4) hours per week of skills training, e.g., daily living skills, social skills, assertiveness skills, etc.;

(3) Family involvement;

(4) Proper medication usage training;

(5) Educational services;

(6) Proper nutrition habits training;

(7) Recreation and social activities;

(8) Prevocational and/or vocational training orientation to community resources;

(9) Orientation to community resources;

~~(10) Medical and follow-up care for residents.~~

~~e. Procedures for handling emergencies twenty-four (24) hours-a-day;~~

~~f. Procedures for resident discharge, terminations and handling elopements;~~

~~g. Procedures for providing or arranging for aftercare/outreach services following discharge from the halfway house.~~

4400.2 The program must employ qualified staff to accomplish the stated goals and objectives. Program staff must at least include the following:

a. A full-time program director;

b. Personnel to provide therapeutic and referral services;

c. Personnel to provide twenty-four (24) hour-a-day supervision;.

d. Personnel to provide clerical services.

e. Personnel to provide housekeeping and maintenance services or documentation that services are secured on a contractual basis.

~~4400.3 The program must provide each resident with written rules and regulations on the date of admission. Documentation must be maintained to show that the individual being served has been made aware of the rules and regulations and agrees to abide by them.~~

XI.I.26. ~~4400.4~~ The duration of each resident's stay must not exceed six (6) months without prior approval ~~from the Department of Mental Health.~~ Requests should be directed to the Director, Bureau of Community Services for approval by the DMH Review Committee.

~~4400.5 The provider must post a certificate from the Department of Mental Health that establishes the total capacity of each half-way house site. The capacity established cannot be exceeded.~~

~~SECTION J - GROUP HOME SERVICES~~

XI.I.27. Group Home Services for adults with serious mental illness provide residential accommodations in a home-like environment, with supervision and training for adults

with a serious mental illness as defined by the Mississippi ~~Department of Mental Health~~. DMH.

~~In addition to standards set forth in this section, all SMI Group Home Service Providers must comply with the requirements set forth in the SMI Group Home Case Record Content Guidelines as well as Part II Organization and Management; Sections B, D and E and Part III Human Services, Section A-H, with the exception of Standard 200.5 c. and d.~~

~~4500.0 The provider of the group home program must have a written statement describing its philosophy in providing group home services and plan for providing services which includes:~~

~~a. A statement of the program's treatment goals and objectives;~~

~~b. Method for accomplishing stated goals and objectives;~~

~~c. Target population and geographic area served;~~

~~d. Number of residents to be served;~~

~~e. Expected results/outcomes;~~

~~f. Evaluation methodology;~~

~~g. Discharge/termination criteria and procedures.~~

~~4500.1 The provider program must maintain written documentation of the following:~~

~~a. The number of employees needed to staff the facility. The minimum staffing for each shift for each day must be approved by the Department of Mental Health and posted in the group home in an area of the home accessible to the public.~~

~~b. No home will be certified without at least one staff person available in the facility at all times when individuals receiving services are present.~~

~~4500.2 The provider of the group home program must have a written plan of service delivery which includes:~~

~~a. Resident selection criteria.;~~

~~b. Procedures for admission to the program;~~

~~c. Procedures for establishing a waiting list;~~

~~d. A schedule of daily activities which includes or provides access to the following:~~

~~(1) Case management and/or other appropriate mental health services;~~

~~(2) Recreational and social activities;~~

~~(3) Other appropriate services.~~

~~4500.3 The provider of the group home program must have a certificate from the Department of Mental Health that establishes the total resident capacity of each group home site. The capacity established cannot be exceeded.~~

SECTION ~~K~~ C- ACUTE PARTIAL HOSPITALIZATION SERVICES

VIII.C.1. Acute Partial Hospitalization is a program that provides 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. Acute Partial Hospitalization 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. Acute Partial Hospitalization may be provided to children with serious emotional disturbance and/or ~~mental retardation~~ intellectual/developmental disabilities or adults with serious and persistent mental illness or ~~mental retardation~~ intellectual/developmental disabilities.

VIII.C.2. The expected outcomes of acute partial hospitalization services include:

d. Individuals will be diverted from inpatient stays.
e. If inpatient hospitalization occurs for an individual, the stay will be shorter than previous stays.

VIII.C.3. ~~4600.0~~ The acute partial hospitalization program must be a part of a written comprehensive plan of crisis stabilization and community support services that includes, at a minimum, family interventions, intensive case management, medication monitoring, and other community support activities. The partial hospitalization program must be designed to

assist individuals in making the transition from acute inpatient services, and/or serve as an alternative to inpatient care.

VIII.C.4. ~~4600.1~~ There must be written policies and procedures implemented for providing acute partial hospitalization services that include at a minimum:

a. 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.

b. Procedures requiring documented medical supervision and follow along with on-going evaluation of the medical status of the individual.

c. Procedures requiring documented support services for families and significant others.

d. Procedures implementing and documenting discharge criteria to include follow-up planning.

VIII.C.5. ~~4600.2~~ The staff for the acute partial hospitalization program must include at each site a full time director (see Standard VI.C.1.a.) who plans, coordinates, and evaluates the service ~~and who has, at a minimum, a Master's degree in a mental heath or related field~~.

VIII.C.6. ~~4600.3 The provider must ensure that the staff on-site are of a sufficient number to provide adequate assistance and supervision in a safe, therapeutic environment and must meet the following minimum requirements:~~ Acute Partial Hospitalization Staff must meet the following minimum requirements:

a. 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. (Staff can be the Program Director who is on site.)

b. 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.

c. 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.

VIII.C.7. ~~4600.4~~ The acute partial hospitalization 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). These services must be documented through an implemented written procedure carried out by the certified DMH/C provider or through contractual agreement.

VIII.C.8. ~~4600.5~~ The Acute Partial Hospitalization Program ~~must:~~ can be operated seven (7) days per week, but must at minimum:

a. Operate a minimum of three days per week;

b. Operate a minimum of four hours per day, excluding transportation time; and

c. Be available twelve (12) months per year.

VIII.C.9. ~~4600.6~~ The Acute Partial Hospitalization 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 Acute Partial Hospitalization Program may only go beyond thirty (30) service days with written justification provided by the attending ~~psychiatrist~~ physician. Stays longer than sixty (60) service days in any year must be justified to the ~~Department of Mental Health~~ DMH and written approval from the Department must be included in the individual's record.

VIII.C.10. ~~4600.7~~ The provider must maintain a daily schedule of therapeutic activities to include individual, group, family, and other activities.

VIII.C.11. ~~4600.8~~ The facility must have sufficient space to accommodate the full range of program activities and services and must provide a minimum of eighty (80) square feet of multipurpose space for each individual served.

~~4600.9 The program must have a certificate from the Department of Mental Health that establishes the total capacity of each acute partial hospitalization site. The number of individuals that the service has been certified to serve cannot be exceeded.~~

SECTION ~~L~~ B- ~~ELDERLY~~ SENIOR PSYCHOSOCIAL REHABILITATION SERVICES

X.B.1. ~~Elderly~~ Senior Psychosocial Rehabilitation is a program of 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.

X.B.2. The expected outcomes of Senior Psychosocial Rehabilitation Services include:

c. Individual's psychiatric symptoms such as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal, and feelings of low self-worth will be alleviated.
d. Individuals' reliance on inpatient hospitalization will decrease.

X.B.3. ~~4700.0~~ The program must be designed to serve elderly persons with serious mental illness or elderly persons with ~~mental retardation~~ intellectual/developmental disabilities who need assistance in socialization, training for daily living skills, use of leisure time activities, or other structured assistance in activities of life.

X.B.4. ~~4700.1~~ No individuals under 50 years of age can be considered for the program. 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.

X.B.5. Senior psychosocial programs must have and average daily attendance at least five (5) individuals.

~~4700.2 The program must have a comprehensive plan for providing services for elderly individuals with serious mental illness and mental retardation/ developmental disabilities that includes, at a minimum:~~

~~a. Outreach strategies to locate and serve the hard to reach elderly individuals in the community. The outreach services must be conducted at least three times a week, with follow-up, and documented, on the Department of Mental Health Elderly Outreach Tracking Chart, kept at each program site.~~

~~b. Individual therapy;~~

~~c. Family therapy;~~

~~d. Group therapy;~~

~~e. Case management;~~

~~f. Information and referral;~~

~~g. Crisis management; and,~~

~~h. Plans for access to other health and mental health services.~~

X.B.6. ~~4700.3~~ For programs located in a community mental health center, 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.

X.B.7. 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.

X.B.8. ~~4700.4~~ The service must have a written schedule of daily activities on file, which should include individual therapy, group therapy, family therapy, socialization activities, activities of daily living, and recreational activities.

X.B.9. ~~4700.5~~ The services must have activities and physical surroundings that are age appropriate.

X.B.10. ~~4700.6~~ The facility must have sufficient space to accommodate the full range of program activities and services and must provide at least ~~eighty (80)~~ sixty (60) square feet of usable space for each participant. (Programs that were operating before July 1, 1999 will be required to have at least 50 square feet per person. Should the program site be changed or if expansion of the existing facility is made to increase the certified capacity, then the program must meet the ~~eighty (80)~~ sixty (60) square foot requirement.)

X.B.11. ~~4700.7~~ Staff must be assigned full time to the Elderly Psychosocial Rehabilitation service.

X.B.12. ~~4700.8~~ The staff must include at each site a full time ~~director~~ supervisor (as defined in Standard VI.C.1 (c))who plans, coordinates, and evaluates the service ~~and who has, at a minimum, a Master's degree in a mental heath/mental retardation or related field.~~

X.B.13. ~~4700.9 The provider must ensure that the staff on-site are of a sufficient number to provide adequate assistance and supervision in a safe, therapeutic environment and must meet the following minimum requirements:~~

Senior Psychosocial Rehabilitation Services staffing patterns must meet the following minimum requirements:

For programs located in a community mental health center:

a. At least one (1) staff member with a minimum of a ~~Master's~~ Bachelor's degree in a mental health~~/mental retardation~~, intellectual/developmental disabilities or related field must be on-site for eight (8) or fewer persons for which the program is certified to serve. (Staff can be the Program ~~Director~~ Supervisor.)

b. At least one (1) staff member with a minimum of a ~~Master's~~ Bachelor's degree in a mental health~~/mental retardation~~ , intellectual/developmental disabilities or related field and at least one (1) support staff ~~with a minimum of a Bachelor's degree in a mental health/ mental retardation or related field when nine (9) through sixteen (16) participants are served.~~ for every eight (8) participants served after the initial eight (8) participants.

~~c. At least one (1) staff with a minimum of a Master's degree in a mental health/mental retardation or related field, at least one (1) staff with a minimum of a Bachelor's degree in a mental health/mental retardation or related field and least one (1) support staff when seventeen (17) through twenty-four (24) participants are served in the program.~~

~~d. For every eight (8) participants over twenty-four (24) served in the program, a minimum of at least one (1) support staff must be added to the on-site staffing ratio.~~

For programs located in a nursing home:

e. At least one (1) staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities

or related field must be on-site for six (6) or fewer persons for which the program is certified to serve. (Staff can be the Program Supervisor.)

f. At least one (1) staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field and one (1) support staff for every six (6) individuals served after the initial six (6) participants.

~~4701.0 The program must have a certificate from the Department of Mental Health that establishes the total capacity of each elderly psychosocial rehabilitation site. The capacity established cannot be exceeded.~~

X.B.14. ~~4701.1~~ A medical screening must be conducted for each individual within thirty (30) days prior to admission and once each year thereafter.

~~4701.2 A nursing plan must be developed in addition to the comprehensive treatment plan and must be reviewed/updated at a minimum every six (6) months. Updates to the nursing plan must be consistent with and reflect medical monitoring by a registered nurse, at a minimum, once during each six-month period.~~

~~4701.3 The service must be planned to involve the individual to the maximum extent possible in community activities.~~

~~4701.4 The service must have a staff development plan that assures all staff are sufficiently trained in the special needs of elderly individuals.~~

~~SECTION M - INTENSIVE RESIDENTIAL TREATMENT SERVICES~~

XI.J.28. ~~Intensive Residential Treatment~~ CSU Services are time-limited residential services designed to serve adults with severe mental health episodes that if not addressed would likely result in the need for inpatient care. The community-based service setting provides intensive mental health assessment and treatment. Follow-up outreach and aftercare services are provided as an adjunct to this service.

~~4800.0 Each intensive residential treatment service provider must develop a written comprehensive description of the program that includes, at a minimum, the following elements:~~

~~a. A mission statement identifying the philosophy and overall goals of the program including a description of the rehabilitative and transitional focus which encourages individuals moving toward self-sufficiency;~~

~~b. A clear description of the characteristics and the needs of the population to be served;~~

~~c. A clear identification of the program components and services to be provided, including the minimum levels of staff supervision required for the protection and guidance of the population to be served.~~

~~4800.1 Each program must have written information that must be made available to all individuals when admission is being considered, which must include at a minimum:~~

~~a. A description of the population to be served;~~

~~b. A description of the types of services offered;~~

~~c. Criteria for acceptance into the programs;~~

~~d. Information regarding the potential for drug screening requirements;~~

~~e. Intake procedures;~~

~~f. General rules and regulations, e.g., visitation hours, passes, telephone use, smoking policy.~~

~~4800.2 The program must accept and serve only those individuals whose needs are compatible with those services provided through the program.~~

XI.J.32. ~~4800.3*~~ Each program must have ~~available~~ the following services ~~on a 24-hour a day, 7 days a week basis~~ available as needed by the resident;

a. Emergency admission;

b. Evaluation;

c. Observation;

d. Crisis counseling;

e. Alcohol and drug counseling;

f. Case management;

~~g. Emergency medical and dental services;~~

~~h. Discharge referrals;~~

i. Therapeutic activities, including recreational, educational, and social/ interpersonal, the intent of which is to involve the individual in reality-oriented events, must be available at least three (3) hours per day. Participation should be documented in the individual's record.

XI.J.30. ~~4800.4~~ The program must maintain one staff member to each four (4) or fewer residents twenty-four (24) hours a day/seven days a week. Each program must post in an area accessible to the public a staffing pattern approved by the ~~Department of Mental Health~~ DMH(signed by the ~~Bureau Chief of Mental Health~~ Director, Bureau of Community Services) to include qualifications for each position and the number of positions per shift for each day of the week. Nursing services must be provided during all shifts.

XI.J.33. 4800.5 Individuals must be involved, to the greatest extent possible, in the operation and decision-making process of the program.

a. Individuals must be involved, at incremental levels depending on capability, in the operation of the program. This involvement may include such things as formulation and monitoring of house rules, as well as the daily operation of the program, e.g., cooking, cleaning, menu planning, activity planning, etc.;

b. Individuals must have meaningful involvement in the evaluation of the program, which must include, at a minimum and as appropriate, family and consumer satisfaction surveys.

~~4800.6 The program must maintain a written structured daily schedule that is designed to assure the delivery of program services.~~

~~4800.7 Each program must implement a written system of medical supervision which addresses, at a minimum:~~

a. Medication management;

b. Personal hygiene care and grooming;

c. Protection from infection and communicable diseases.

4800.8 Menus must provide for varied, balanced, and adequate diets, as well as any medically necessary diets for all individuals, and copies must be kept on file.

4800.9 Provision must be made for each individual to have clean, comfortable, well-fitting clothes and shoes.

4801.0 The facility location must be approved by the Department of Mental Health.

4801.1 Whenever there is a reason to believe that the security of a program or the health of anyone is endangered, a search of an individual's person, room, locker, or possessions must be conducted if authorized by the program director or designee, as defined in program policies and procedures. The reason for the search must documented and maintained in the record of each individual whose room, locker or possessions were searched.

4801.2* The program must have emergency exit doors operated by a magnetic/ electronic (or similar) release system. This system must be in a readily accessible and secured location that is accessible only by staff.

4801.3 The provider must conduct an annual evaluation of the program and based on this evaluation must review, develop, and implement indicated program and administrative changes in accordance with the defined mission of the program.

4801.4 The outcome-based evaluation system must address a variety of measures, which must include at least two of the following:

a. The number of admissions to the state hospitals;

b. The number of pre-evaluation screenings for civil commitment;

c. Satisfaction surveys - family and/or individual;

d. Hospital recidivism rates of individuals utilizing the service.

~~NOTE: In addition to the following two standards regarding use of seclusion, providers of Intensive Residential Service must also meet all standards in Part III, Section C Rights of Individuals Receiving Services.~~

XI.J.36. ~~4801.5 γ~~ CSU Providers utilizing seclusion must establish and implement written policies and procedures specifying appropriate use of seclusion. The policy/ procedures must include, at a minimum:

a. Clear definition(s) of seclusion and the appropriate conditions and documentation associated with its use. Seclusion is defined as behavioral control technique involving locked isolation. Such term does not include a time out.

b. Requirements that seclusion is used only in emergencies to protect the individual from injuring himself/herself or others. AEmergency@ 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;

c. Requirements 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;

d. Requirements 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, and that such orders must be documented in the case record. The following requirements must be addressed in the polices and procedures regarding the use of seclusion and implementation (as applicable) documented in the individual case record:

(1) Orders for the use of seclusion must never be written as a standing order or on an as needed basis (that is, PRN);

(2) The treating physician must be consulted as soon as possible, if the seclusion is not ordered by the individual's treating physician;

(3) A physician or other licensed independent practitioner must see and evaluate the need for seclusion within one hour after the initiation of seclusion;

(4) Each written order for seclusion must be limited to four 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;

(5) Seclusion must be in accordance with a written modification to the comprehensive treatment/service/habilitation plan of the individual being served;

(6) Seclusion must be implemented in the least restrictive manner possible;

(7) Seclusion must be in accordance with safe, appropriate techniques; and,

(8) Seclusion must be ended at the earliest possible time.

e. Requirements that seclusion is not used as a form of punishment, coercion, or staff convenience;

f. Requirements that all staff who have direct contact with individuals being served must have ongoing education and training in the proper, safe use of seclusion;

g. 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; and,

h. Requirements that the original authorization order of the seclusion may only be renewed for up to a total of twenty-four (24) hours (in accordance with the limits of these standards) by a licensed physician or licensed independent practitioner, if less restrictive measures have failed.

XI.J.35. ~~4801.6 γ~~ If a program uses a room for seclusion(s), the program must obtain written approval of the use of such room from the ~~Department of Mental Health~~ Director, Bureau of Community Services prior to its use for seclusion. To be approved for use for seclusion by the ~~Department of Mental Health~~ DMH, a room must meet the following minimum specifications:

a. Be constructed and located to allow visual and auditory supervision of the individual;

b. The dimensions of the room must be at least 48 square feet; and,

c. Be suicide resistant and have break resistant glass (if any is utilized in the room or door to the room).

~~SECTION N - SUPERVISED HOUSING SERVICES~~

~~Supervised Housing is a form of housing service that provides a residence for three or fewer individuals in a single living unit. Individuals function with a greater degree of independence than in a group home. Supervised Housing generally has staff responsible for the housing unit. Contacts with the individual are needed on a regular basis of at least several times a month. During the day individuals may engage in activities of the provider program, supported or transitional employment, competitive employment, or other community activities.~~

~~4900.0 The individuals living in the supervised housing program service must be registered clients, with a serious mental illness, of the provider program.~~

~~4900.1 The program must have a written plan of service delivery which includes:~~

~~a. Resident selection criteria;~~

~~b. Procedures for admission to the program;~~

~~c. Procedures for establishing a waiting list;~~

~~d. Methods, procedures, and activities planned to provide independent living opportunities for the individual;~~

~~e. Procedures for individual access to services in the event of an emergency;~~

f. Discharge/termination criteria and procedures.

4900.2 The service must be designed to promote and allow independent decision making by the individual.

4900.3 Each housing unit must have:

a. A fire extinguisher that is securely mounted in the kitchen. This fire extinguisher must be regularly checked by staff and must be inspected at least annually to assure that it is operable. Each individual living in the apartment must be trained in the use of the fire extinguisher;

b. Auditory smoke/fire alarms, with a noise level loud enough to awaken individuals. These alarms must be located in the kitchen, living area, and each bedroom. Each individual must be trained in the use and maintenance of such alarms;

c. 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. Each individual must be trained in the use and maintenance of such alarms.

4900.4 The housing unit must be located in an area that is safe and is convenient to community activities such as shopping centers, retail stores, public recreational facilities, etc. The location of the housing unit must be approved by the Department of Mental Health.

4900.5 To the degree possible, the residents must have the authority and responsibility to operate the housing unit as they see fit.

4900.6 The supervised housing activities and physical arrangement must be designed to promote individual independence and encourage independent living.

4900.7 The provider must have a method to determine individual satisfaction with the service. This evaluation must include, at a minimum, the satisfaction with location and upkeep of the apartment/residence, the support provided in achieving independence, accessibility to community resources and services, and the ability to make independent decisions. This evaluation must be conducted at least annually, with results on file for review.

~~4900.8 Support must be available as needed to provide:~~

~~a. Money management training;~~

~~b. Independent living skills training and support;~~

~~c. Use of community resources training and support;~~

~~d. Access to mental health, health, and other community services.~~

~~PART IX~~

~~ADULT DAY CENTER SERVICES~~
~~FOR~~
~~PERSONS WITH ALZHEIMER'S DISEASE AND OTHER DEME~~NTIA

PART XIV

ALZHEIMER'S AND OTHER DEMENTIA SERVICES

XIV.A. Standards in this section apply to Adult Day ~~center programs~~ Services for persons with Alzheimer's disease and other dementia. These programs must also comply with applicable standards under Part I~~, Procedures for Certification, Part II, Organization and Management, Part III, Human Services, and Part IV, Bureau of Mental Health General Standards of the current~~ Minimum Standards for Community Mental Health/Mental ~~Retardation Services.~~

through Part VII of the DMH Operational Standards.

~~BACKGROUND AND TARGET POPULATION~~

XIV.A.1. The key elements of Adult Day Center programs are an interdisciplinary approach to meeting goals for individuals served in the program and the variety of services offered by the program to meet individuals' needs. Adult Day ~~Centers~~ 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, optimizing the health of the individuals. Adult Day ~~Centers~~ Services provide a structured environment for individuals with Alzheimer's disease and related dementia; counseling for family members and/or other care givers; and education and training for individuals providing services to those with Alzheimer's disease and related dementia and also to family members and/or care givers; and respite. By supporting families and care givers, adult day centers enable individuals with Alzheimer's disease and other dementia to live in the community.

XIV.A.2. Adult Day ~~Centers~~ Services 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. Adult Day ~~Centers~~ Services assess the strengths and needs of individuals and families and offer services to build on their strengths.

XIV.A.3. Expected outcome for Adult Day Services is that individuals with Alzheimer's disease and other dementia and their family members/caregivers are supported in their communities.

XIV.A.4. Adult Day ~~Centers~~ Services provide services for adults with physical and psychosocial impairments, who require supervision, including:

a. Persons who have few or inadequate support systems.

b. Persons who require assistance with activities of daily living (ADLs).

c. Persons with memory loss and other cognitive impairment(s) resulting from Alzheimer's and other dementia that interfere with daily functioning.

d. Persons who require assistance in overcoming the isolation associated with functional limitations or disabilities.

e. Persons whose families and/care givers need respite.

f. Persons who, without intervention, are at risk of premature long-term placement outside the home because of memory loss and/or other cognitive impairment(s).

~~SECTION A - GENERAL STANDARDS~~

XIV.A.5. ~~5000.0~~ The ~~programs~~ providers providing Adult Day ~~Center~~ Services must meet the following minimum staffing requirements:

a. A full-time Program ~~Director/Administrator~~ Supervisor (see Standard VI.C.1(c)) with ~~a minimum of a Master's degree in a mental health, social or health related field and~~ (1) at least one year of supervisory experience in a mental health, social or health service setting or (2) comparable technical and human services training, with demonstrated competence and experience as a manager in a human services setting;

b. A full-time Activities Coordinator, who can also serve as Assistant Program ~~Director~~ Supervisor, with a minimum of a Bachelor's degree in recreational, music or art therapy and at least one year of experience in developing and conducting activities for the population to be served;

c. A full-time Program Assistant with a minimum of an Associate's degree and at least one year of experience in working with adults in a health care or social service setting;

d. A Registered Nurse with at least one year of experience (with availability on a contractual, full time or part time basis of no less than eight hours per week);

e. Secretary/Bookkeeper with a minimum of a high school diploma or equivalent and skills and training to carry out the duties of the position;

f. ~~Volunteers must be individuals who~~ If volunteers are utilized, individuals who volunteer 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. ~~(See also Standard 20.6)~~

~~5000.1 Staff must be of a sufficient number and qualified in skills necessary to provide essential administrative and service functions.~~

XIV.A.6. ~~5000.2~~ The ratio of staff to individuals served by the program must be at least one full-time staff member per four individuals served.

~~5000.3 The program must develop written policies and procedures that address at a minimum:~~

~~a. Procedures for admission and readmission to the program;~~

~~b. The process to be followed when an individual is found ineligible for admission;~~

~~c. The process or requirements for collecting intake information;~~

~~d. Procedures for establishing a waiting list;~~

~~e. A schedule of daily activities;~~

~~f. Consequence of individuals' noncompliance with program rules and regulations;~~

~~g. Conditions for transfer of individuals served to another program.~~

~~5000.4 The Intake/Assessment must document that the following areas have been addressed/included:~~

~~a. Physical and mental health status, including diagnosis and current treatment;~~

~~b. Name(s) of primary physician and other physician(s) involved in the treatment of the individual being served;~~

c. Other community agencies involved in providing services or support;

d. Assessment of level of functioning in performing daily living skills;

e. A written medical report, provided by a licensed physician that reflects the current health status of the individual to be served (within thirty (30) days prior to admission). This health status report must be obtained prior to admission and must be made a part of the individual's case record;

f. Name and contact information for a designated health care provider to be contacted in the event of an emergency and/or for ongoing care.

5000.5 A written Plan of Care must be developed from the intake/assessment information for each individual being served, within seven working days of the intake/assessment.

5000.6 The Plan of Care must be updated, at a minimum, every six months following the date of intake or more often as needed.

5000.7 The individual and family member(s)/caregivers must participate in the development of the written Plan of Care. Such participation must be documented by the individual's and family members'/caregivers' signature(s) on the Plan of Care.

5000.8 An individualized activity plan must be developed as part of the written Plan of Care, with activities related specifically to objectives in the Plan of Care.

Therapeutic Activities

XIV.A.7. 5010.0 The adult day services program for Alzheimer's Disease and other dementia 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:

a. Personal interaction;

b. Individualized activities;

c. Small and large group activities;

d. Intergenerational experiences;

e. Outdoor activities, as appropriate;

f. Self-care activities;

g. Culturally and ethnically relevant celebrations.

~~5010.1 Activities must be designed to promote personal growth and enhance the self-image and/or maintain or improve their functioning level to the maximum extent possible. These activities must reflect individual strengths, needs and preferences of individuals served by the program, as reflected by intakes/assessments and Plans of Care.~~

XIV.A.8. ~~5010.2~~ 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.

XIV.A.9. ~~5010.3~~ Individuals must be allowed time for rest and relaxation and to attend to personal and health care needs.

XIV.A.10. ~~5010.4~~ 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.

XIV.A.11. ~~5010.5~~ Creative arts activities must be provided to improve or maintain physical, cognitive, and/or social functioning of individuals served by the program.

Education and Training

XIV.A.12. ~~5020.0~~ 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 ~~on the Plan of Care and on the summary of staffing forms, at least monthly.~~ in the case record. A family education log should be kept by the Program Supervisor.

XIV.A.13. As an opportunity for ongoing training, 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 should be made on a monthly basis or more frequently if determined necessary by the Program Supervisor.

Assistance with Activities of Daily Living

XIV.A.14. 5030.0 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.

Food Services

XIV.A.15. ~~5040.0~~ 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.

XIV.A.16. ~~5040.1~~ 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.

~~NOTE: Programs that serve meals on site must meet all applicable standards under Part III, Section A - Environmental/Safety.~~

Facility

XIV.A.17. ~~5050.0~~ Each adult day service center, when it is co-located in a facility housing other services, must have its own separate, identifiable space for all activities conducted during operational hours.

XIV.A.18. ~~5050.1~~ The adult day service center facility must provide at least sixty (60) square feet of program space for multipurpose use for individuals served in the program. A single program may serve no more than ~~twenty (20)~~ twenty-five (25) individuals at a time.

XIV.A.19. ~~5050.2~~ 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.

XIV.A.20. ~~5050.3~~ The facility must have an identified separate space available for individuals and/or family/caregivers to have private discussions with staff.

XIV.A.21. ~~5050.4~~ The facility's restrooms must be located as near the activity area(s) as possible.

XIV.A.22. ~~5050.5~~ The facility must have a rest area for individuals served in the program and must have a minimum of one reclining chair per four individuals served in the program.

XIV.A.23. ~~5050.6~~ The facility must utilize an operable electronic security system that has the capacity to monitor unauthorized entrance or egress, or other movement through the entrance/exits.

XIV.A.24. ~~5050.7~~ Outside space that is used for outdoor activities must be safe, accessible to indoor areas, and accessible to individuals with disability(ies).

XIV.A.25. ~~5050.8~~ The program must have secure, exterior pathway(s), a minimum of four (4) feet in width.

XIV.A.26. ~~5050.9~~ Adequate outside seating must be provided.

XIV.A.27. ~~5051.0~~ 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.

~~PART X~~

~~OTHER COMMUNITY SERVICES~~
~~FOR INDIVIDUALS WITH MENTAL ILLNESS,~~
~~MENTAL RETARDATION/DEVELOPMENTAL DISABILITIES~~
~~OR SUBSTANCE ABUSE~~

~~Standards contained in this section apply to providers of services as specified herein for adults and/or children with mental illness, mental retardation/developmental disabilities or substance abuse diagnoses. Providers must also meet all general standards as applicable to the populations served. (For example, providers of Mental Illness Management Services (in Part X) for children with serious emotional disturbances must also meet general standards in Parts I-III, Part V, and Part VI, Section A - Mental Health Services for Children and Youth General Standards.)~~

SECTION ~~A~~ E- SCHOOL BASED SERVICES (CASE MANAGEMENT SERVICES)

IX.E.1. School-Based Services are professional therapeutic services provided in a school setting that are more intensive than traditional case management services. School based services include consultation and crisis intervention. School-Based Services may be provided to children with serious emotional disturbance and children with ~~mental retardation~~ intellectual/developmental disabilities.

IX.E.2. Consultation, offered through School Based Services, consists of ~~is~~ professional advice and support provided by a therapist to a child's teachers, guidance counselors, and other school professionals, as well as to parents, community support providers, treatment teams, court systems, etc. Consultation may be provided as a form of early intervention when no formal treatment process has been established. Parent and/or teacher conferences are included in this service component.

IX.E.3. Crisis Intervention, offered through School Based Services, consists of ~~is~~ therapeutic engagement during the school day at a time of internal or external turmoil in a child's life with a focus on producing effective coping. Crisis intervention strategies may be directed toward alleviating immediate personal distress, assessing the precipitants that produced the crisis, and/or developing preventative strategies to reduce the likelihood of future similar crises. This service may be provided to family members when their involvement relates directly to the identified needs of the child.

IX.E.4. The expected outcomes of School Based Services include:

a. Child/youth's immediate personal distress is alleviated by assessing the precipitants that produced the crisis.
b. Child/youth's future crises are mitigated.
c. Child/youth is able to remain in the classroom setting.

IX.E.5. ~~5100.0~~ Individuals receiving school based services ~~(case management services)~~ must meet eligibility requirements for one or more of the following service categories:

a. Children who are determined to have a serious emotional disturbance (SED);

b. Children with ~~mental retardation~~ intellectual/developmental disabilities.

IX.E.6. It is not necessary that a child/youth be receiving traditional case management services in order to receive School-Based Services.

IX.E.7. ~~5100.1~~ The provider of School-Based Services must develop, compile, and implement an annual written plan for providing school based services that must include a description of how the following services will be provided:

a. Collateral contacts with teachers, guidance counselors, therapists (i.e. speech, physical, etc.), medical personnel, special education teachers, and other school professionals, as well as parents, community service providers, treatment teams, and court systems to enhance coordination of services on behalf of the child.

b. Consultative services to address issues such as increasing interpersonal skills, managing noncompliant behavior, early intervention to minimize maladaptive behaviors, and recognizing the need for more intensive treatment and making referrals.

c. Consultation with parents centered on clarifying individual needs and assisting in accessing services on behalf of the child.

d. Consultation through conferences with parents/legal guardians, teachers, guidance counselors, therapists, medical personnel, special education teachers, and/or other school professionals.

e. Crisis resolution services to address issues that require immediate intervention in the school or family setting. Crisis Resolution Services can also provide interventions where their involvement relates directly to the identified needs of the child (e.g., understanding ADHD).

f. Crisis resolution strategies that are employed to reduce the immediate distress, to assess the precipitant(s) that resulted in the crisis, or, to reduce the chance of future crisis situations through the implementation of preventative strategies.

IX.E.8. ~~5100.2~~ School-Based Services must be clearly distinguishable and separate from the educational components required by the school. Educational interventions are not considered part of School-Based Services.

IX.E.9. ~~5100.3~~ There must be a written agreement on file between the provider and the school in which School-Based Services will be provided. This agreement must include a statement of confidentiality between the school-based therapist and involved school personnel. ~~(See Standard 1500.6.)~~

IX.E.10. ~~5100.4~~ ~~Students~~ Children/youth who are actively enrolled in school, but temporarily out of school (e.g. suspensions, illness) remain eligible for this service. ~~Students~~ Children/youth who are not actively enrolled in school or who are not enrolled in a DMH certified program (e.g.; admitted to inpatient psychiatric care) are not eligible for this service.

~~5100.5 A release of information must be in the file allowing the designated program staff to consult with school officials. This release of information must be updated at least once each school year.~~

IX.E.11. ~~5100.6~~ The content of the consultative session or any collateral meeting regarding the child must be documented in a progress note. The activities must be within the service content described in Standard ~~5100.1, a.-f.~~ IX.E.7.

IX.E.12. ~~5100.7~~ The title of the person/persons involved in the consultative session must be documented in the progress note.

~~5100.8 Providers of School-Based Services are required to use the record system and time lines established in the following guides and standards: for children with mental retardation/developmental disabilities, the Bureau of Mental Retardation/Developmental Disabilities Record Guide; and, for children with SED, the standards in Part III - Human Services, Section E - Case Record Management and Record Keeping and Part V - Bureau of Mental Health General Standards, Section B - Case Record Management and Record Keeping.~~

SECTION ~~B~~ F- MENTAL ILLNESS MANAGEMENT SERVICES (MIMS)
~~(CASE MANAGEMENT SERVICES)~~

IX.F.1. Mental Illness Management Services (MIMS) are intensive case management services with a therapeutic focus. MIMS may be provided to children with SED and children with ~~MR~~ ID/DD children or adults with SMI and adults with ~~MR~~ ID/DD adults in their current living situation, natural environment, and other appropriate community settings. The scope of Mental Illness Management Services is sufficient to ensure ongoing evaluation and control of psychiatric symptoms while restoring functioning necessary for successful community living.

IX.F.2. MIMS are distinguished from traditional case management services by the higher level of professional expertise/skill of the providers, required to effectively address the more complex mental health needs of the individual receiving the service. Additionally, MIMS provides indirect services to support program participants in the community (i.e., family support, collaboration of other programs/services).

IX.F.3. The expected outcome of MIMS is that the individual's psychiatric symptoms are alleviated in order for the individual to maintain successful community living.

~~5200.0 Individuals receiving MIMS must meet eligibility requirements for one or more of the following service categories:~~

~~a. Adults who are determined to have a serious mental illness (SMI).~~

~~b. Children and youth who are determined to have a serious emotional disturbance (SED).~~

~~c. Individuals (adults or children) with mental retardation/ developmental disabilities (MR/DD).~~

IX.F.4. ~~5200.1~~ The provider must develop and implement written policies and procedures for providing MIMS that must at a minimum:

a. Describe how the target population is identified.

b. Describe what services will be included in MIMS to address the following:

(1) Symptom evaluation and monitoring.

(2) Intervention and assistance with resolution of crisis situations.

(3) Provision/enhancement of environmental supports.

(4) Prevention of the need for more intensive treatment services.

(5) Other services/activities designed to increase/prompt independence.

c. Describe how MIMS is coordinated with other case management services, crisis services, and other community support system activities.

d. Defines the credential (Master's degree-see ~~20.5 x~~ Standard VI.C.1 (l) of the direct service provider.

IX.F.5. ~~5200.2~~ The MIMS ~~supervisor~~ Program Director and a physician must certify the necessity of treatment and the appropriateness of care with a signature and date on the ~~Comprehensive Treatment Plan.~~ Individual Service Plan.

IX.F.6. ~~5200.3~~ The MIMS ~~supervisor~~ Program Director and assigned staff must reevaluate the individual's need for continued service at a minimum of every six (6) months while the individual is receiving MIMS. Documentation to support the need for continuation of services must be indicated in a progress note. This certification of need for continued treatment must be justified in the record and be confirmed by the MIMS ~~supervisor's~~ Program Director's and physician's signatures on the ~~Comprehensive Treatment Plan.~~ Individual Service Plan.

IX.F.7. ~~5200.4~~ MIMS ~~supervisors~~ Program Directors must have (1) administrative experience; (2) ~~a Master's degree in a mental health or related behavioral health field;~~ meet educational as outlined Standard VI.C.1 (a) and (3) hold a professional license ~~(ex. Licensed Professional Counselor, Psychologist, Licensed Master's Social Worker, or a Physician)~~ or ~~a~~ DMH ~~credentialed~~ credentials as mental health ~~therapist or DMH credentialed mental retardation~~ or intellectual/developmental disabilities therapist~~, as appropriate to the population served.~~

IX.F.8. ~~5200.5~~ The ~~Comprehensive Treatment Plan~~ Individual Service Plan must be individualized and address needs for intensive services identified in the intake/assessment. These services can include

symptom evaluation/monitoring, group and individual therapeutic intervention, supportive counseling and crisis management, provision enhancement of environmental supports, and other services directed toward helping the individual live successfully in the community.

~~5200.6 Case records must include an individual contact summary for each individual receiving MIMS which includes service provided, place of service, and a daily total of the time spent with the individual receiving the service.~~

IX.F.9. ~~5200.7~~ The program must have a process for the evaluation of the individual at least every six months to determine the individual's readiness to resume regular case management services ~~and/or other appropriate services following discharge from MIMS.~~

IX.F.10. ~~5200.8~~ A discharge summary for closed cases must be maintained in the case record, as described in Standard ~~200.7~~ IV.H.7(i), including staff responsible for continuation of services included in the Discharge Plan.

IX.F.11. ~~5200.9~~ The caseload assignments of individual staff providing MIMS are as follows:

a. Full-time MIMS provider-maximum of thirty (30) individuals.

b. Combination of duties to include MIMS - maximum of fifteen (15) individuals.

SECTION ~~C~~ G - INDIVIDUAL THERAPEUTIC SUPPORT SERVICES

IX.G.1. Individual Therapeutic Support is the provision of one-on-one supervision of the individual during a period of extreme crisis in which hospitalization would be necessary without this service. The service may be provided in the individual's home, school, or any other setting that is part of his/her environment. This service provides therapeutic support during a time when the individual is unable to participate in regular treatment activities (ex: Acute Partial Hospitalization, Day Treatment Programs, etc.). The focus is on the reduction/elimination of acute symptoms.

IX.G.2. The expected outcome of Individual Therapeutic Support Services is for the individual's acute symptoms are managed in the individual's natural environment and hospitalization is diverted.

IX.G.3. ~~5300.0~~ Individuals receiving Individual Therapeutic Support must meet eligibility requirements for one or more of the following service categories:

a. Adults who are determined to have a serious mental illness (SMI).

b. Children and youth who are determined to have a serious emotional disturbance (SED).

c. Individuals (adults or children) with ~~mental retardation~~ intellectual/ developmental disabilities (~~MR~~ ID/DD).

IX.G.4. ~~5300.1~~ Individual Therapeutic Support Services provide one-on-one brief interaction in environments that are extremely stressful for the individual on a scheduled short-term basis to observe the individual and to assist them in transition back into integrated settings. Staff providing Individual Therapeutic Support must have a high school diploma or GED ~~and must be certified by DMH as a DMH-Direct Care Worker or a Certified Nursing Assistant~~.

IX.G.5. ~~5300.2~~ Supervision of staff providing Individual Therapeutic Support Services must be provided by a staff member with a Master's degree in a mental health or related behavioral health field and professional license or appropriate DMH credentials.

IX.G.6. ~~5300.3~~ A supervisor must maintain documentation of direct supervision (contact) of the staff providing Individual Therapeutic Support Services, at a minimum, once per day.

IX.G.7. ~~5300.4~~ Each contact must be recorded in a progress note not less than daily and must include the total amount of time spent with the individual receiving individual therapeutic support.

~~5300.5 A physician's order for each service event is required indicating that inpatient care would be otherwise necessary without Individual Therapeutic Support being provided.~~

IX.G.8. The need for Individual Therapeutic Support Services must be justified in the individual's Individual Service Plan.

SECTION ~~D~~ C- DAY SUPPORT (PSYCHOSOCIAL REHABILITATIVE SERVICES)

~~Day Support is a program of structured activities designed to support and enhance the role functioning of 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. 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. This program is the least intensive psychosocial rehabilitative service available.~~

X.C.1. Day Support must provide structured, varied and age appropriate activities (both active and passive) and the option for individuals to make choices about the activities in which they participate. The activities must be designed to support and enhance the individual's independence in the community through the provision of structured supports. Program activities must aim to improve social adaptation, physical coordination, daily living skills, employment awareness, and task completion.

X.C.2. Expected outcomes of Day Support Services include:

a. Individual's reality orientation, social adaptation, physical coordination, daily living skills, time/resource management and task completion skills of individuals served will improve.
b. Individual's psychiatric symptoms such as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth will be alleviated.

X.C.3. Day Support Services must include, at a minimum;

a. Community integration and job exploration

b. Job skills training;

c. Leisure-time activities training;

d. Daily social skills training;

e. Coping skills training;

g. Improvement of the individual's current abilities and skills.

g. The capacity for personal growth;

h. The enhancement of self-image;

i. Assistance with maintaining and learning new skills which promote independence;

j. Assistance with developing interpersonal relationships;

k. Assistance with eliminating isolation; and,

l. Assistance with improving physical and emotional well being.

5400.0 Individuals receiving Day Support Services must meet eligibility requirements for one or more of the following service categories:

a. Adults ~~who are determined to have~~ with a serious mental illness (SMI).

b. ~~Individuals (adults)~~ Adults with ~~mental retardation~~ intellectual/developmental disabilities (~~MR~~ ID/DD).

c. Individuals (adults) with a substance abuse diagnosis and with a history of substance abuse.

X.C.5. ~~5400.1~~ The program must operate ~~a minimum~~ 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 ~~of five (5) hours per day (excluding travel time), five (5) days per week,~~ and have flexible hours (e.g., afternoon and evenings). Planned activities must be available whenever the center is in operation.

X.C.6. ~~5400.2~~ 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**.**

~~5400.3 The program must have a minimum of five (5) individuals per program and must not exceed the certified capacity.~~

X.C.7. ~~5400.4~~ The program must have sufficient space to accommodate a full range of service activities and must provide a minimum of 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.

X.C.8. ~~5400.5~~ Written policies and procedures, including a description of the program, must be maintained and must include, but not be limited to, the following:

a. The purpose, goals, and objectives of the program;

b. Description of the population(s) to be served, including admission criteria, which indicate that individuals served by the program ~~do not require~~ are not appropriate for the more intensive services offered in a clubhouse or a work activity center, but still need structured daily activities.

c. The daily hours of operation and number of people to be served at each program site.

d. Description of the daily activities to be available.

~~5400.6 The structured activities of the program must be designed to:~~

~~a. Maintain individuals in an environment less restrictive than inpatient or therapeutic residential treatment;.~~

~~b. Develop daily living, social and other therapeutic skills;~~

~~c. Promote personal growth and enhance the self image and/or improve or maintain the individual's abilities and skills;~~

~~d. Provide assistance in maintaining and learning new skills that promote independence;~~

~~e. Develop interpersonal relationships that are safe and wanted by the individual to eliminate isolation; and,~~

~~f. Improve physical and emotional well being.~~

~~5400.7 The provider must have structured activities that include the following as appropriate for each individual:~~

~~a. Social skills training.~~

~~b. Group therapy.~~

~~c. Individual therapy.~~

d. Training on use of leisure time activities.

e. Coping skills training.

5400.8 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.

~~5400.9 The program must hold a certificate from the Department of Mental Health that establishes a total number of individuals that can be served at each day support service site. The number of individuals for which the service has been certified to serve cannot be exceeded.~~

~~5401.0 Staffing ratio must be at least one staff member at all time for each 12 adult individuals the program is certified to serve. Depending on the physical capability and population service, additional staff may be required to ensure the health, safety, and welfare of the individuals served.~~

~~5401.1 The designated director must have a Bachelor's degree in mental health/mental retardation or a related field and will 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.~~

~~5401.2 Treatment Plans must be developed in accordance to the guidelines established in the Bureau of Mental Retardation Record Guide or Bureau of Mental Health Record Guide as appropriate for the diagnosis for the individuals served in the program.~~