Title 24: Mental Health

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

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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.

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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 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 Community Mental Health/Intellectual Disability/Substance Abuse Community Service Provider.

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 all standards in Parts II through VII, as

well as all applicable standards in Parts VIII through XIX 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 ID/DD 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 XIX 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 MCA Section 41-19-31 et seq. and other community mental health service providers operated by entities other than the DMH that meet DMH requirements of and are determined necessary by DMH to be a designated and approved mental health center (DMH/C) must provide the following minimum services throughout the CMHC's entire catchment area:

a. Adult Mental Health Services

(1) Outpatient Therapy
(2) Case Management Services
(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 est. under MCA Section 41-19-31 et seq.)

b. Children and Youth Mental Health Services

(1) Day Treatment Services
(2) Outpatient Therapy
(3) Case Management Services
(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)
(8) Making a Plan (MAP) Teams

c. Alcohol and Other Drug Disorders Services

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

d. Intellectual/Developmental Disabilities Services

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

SECTION D - APPLICATION FOR CERTIFICATION GUIDELINES

I.D.1. Initial Certification Process:

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

B. All applicants for initial certification must submit an Application Package that addresses all information required on the current Application Checklist, including any attachments as indicated. The applicant must submit required information for each service and each service site 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.

C. The Application Package, attachments and any required fees must be submitted to the Division of Accreditation and Licensure. Incomplete applications will not be reviewed.

D. The Department may request additional information during review of the initial Application Package. Within 30 days of receiving the completed Application Package for Initial Certification, the DMH Review Committee will make a determination regarding whether the Application Package is acceptable and whether or not the initial certification process can proceed.

E. All applicants for initial certification must be incorporated in Mississippi and have an established office physically located in Mississippi before the Application for Initial Certification will be reviewed.

F. After approval of the Application Package by the DMH Review Committee, DMH staff will conduct a desk review and make on-site visits (if applicable) to review the physical location for compliance with DMH standards. The DMH has 30 days from the date the DMH Review Committee approves the Application Package to complete the desk review of documents and on-site review(s), as applicable.

G. An onsite visit, if necessary, will be conducted at a mutually agreed upon time during the thirty (30) days from the date the Application Package is approved by the DMH Review Committee.

H. When an applicant for initial certification is found to be in compliance with all DMH criteria for initial certification and all on-site requirements are met, the applicant will be issued a Certificate of Operation within fifteen (15) days of the completion of the DMH review of documents and site(s) (if applicable).

I. Providers/agencies requesting initial certification cannot seek reimbursement for the services provided until there is a valid Certificate of Operation.

J. For DMH/H providers, DMH will notify the Division of Medicaid (DOM) of the applicant's certification status. The applicant must receive a DOM provider number, along with the DMH Certificate of Operation in order to render and claim reimbursement for ID/DD Waiver Services.

K. If deficiencies are found during the on-site visit or during the desk review, DMH will issue a written report of findings to the Executive Director of the agency seeking certification within 15 days of the completion of the desk review.

L. The Executive Director of the agency seeking certification must submit a plan of compliance to DMH within ten (10) days from the date of the DMH written report.

M. Certificates of Operation will not be issued until all deficiencies found with environment/safety are corrected and either appropriate documentation submitted to the DMH to verify compliance or a DMH on-site follow-up review for direct verification.

N. If the plan of compliance and on-site follow-up review (if applicable) is satisfactory, DMH will notify the provider/agency in writing, within ten (10) days of receipt of the plan of compliance and a Certificate(s) of Operation will be issued.

O. For DMH/H providers, DMH will notify the Division of Medicaid (DOM) of the applicant's certification status. The applicant must receive a DOM provider number, along with the DMH Certificate of Operation in order to render and claim reimbursement for ID/DD Waiver Services.

I.D.2. <u>Application Process for New/Additional Services and/or Sites:</u>

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

B. Applicants that currently hold a valid DMH certification and are applying for certification of additional/new services/sites must submit an Application Package that addresses all information required on the current Application Checklist, including any attachments as indicated. The applicant must submit separate Application Packages for each service and each service site 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.

C. If an agency physically modifies an existing site, the site is considered a “new” site and will be reviewed as such.

D. If an agency closes services at a site but plans to later reopen the program (e.g., Day Treatment) at the same site, the provider must submit an Application Package for New/Additional Service even if some or all of the same individuals served in the closed program will be in the new program.

E. The Department may request additional information during review of the Application Package. Within 30 days of receiving the completed Application Package, the DMH Review Committee will make a determination regarding whether the Application Package is acceptable and whether or not the initial certification process can proceed.

F. After approval of the Application Package by the DMH Review Committee, DMH staff will conduct a desk review and make on-site visits (if applicable) to review the physical location for compliance with DMH standards. The DMH has 30 days from the date the DMH Review Committee approves the Application Package for New/Additional Service or Application for New Site to complete the desk review of documents and on-site review(s), as applicable.

G. An onsite visit, if necessary, will be conducted at a mutually agreed upon time during the thirty (30) days from the date the Application Package is approved by the DMH Review Committee.

H. When an applicant for new/additional service(s) or site(s) is found to be in compliance with all DMH criteria for such and all on-site requirements are met, the applicant will be issued a Certificate of Operation within 15 days of the completion of the DMH review of documents and site(s) (if applicable).

I. Providers/agencies requesting certification of a new service for which they were previously not certified cannot seek reimbursement for the service until there is a valid Certificate of Operation.

J. For DMH/H providers, the DMH will notify DOM that the applicant has been approved to provide a service for which they do not currently have a provider number. (A new provider number is not necessary to open a new service site.) The applicant/ must receive a DOM provider number, along with the DMH Certificate of Operation in order to render and claim reimbursement for ID/DD waiver services.

K. If deficiencies are found during the on-site visit or during the desk review, the DMH will issue a written report of findings to the Executive Director of the agency within 15 calendar days of the completion of the desk review.

L. The Executive Director of the agency seeking certification must submit a plan of compliance to DMH within ten (10) days from the date of the DMH written report.

M.. Certificates of Operation will not be issued until all deficiencies found with environment/safety are corrected and either appropriate documentation submitted to the DMH to verify compliance or a DMH on-site follow-up review for direct verification.

N. If the plan of compliance and on-site follow-up review (if applicable) is satisfactory, DMH will notify the provider/agency in writing, within ten (10) days of receipt of the plan of compliance and a Certificate(s) of Operation will be issued.

O. For DMH/H providers, the DMH will notify DOM that the applicant has been approved to provide a service for which they do not currently have a provider number. (A new provider number is not necessary to open a new service site.) The applicant must receive a DOM provider number, along with the DMH Certificate of Operation in order to render and claim reimbursement for ID/DD waiver services.

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

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

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 package 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 the application package 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 they are granted 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 Operational 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.

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 and other drug 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 the Operational Standards and/or audit findings;
c. Denial of request for a waiver of a DMH operational standard; or
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 ten (10) days from the date of the final notification by the Department of Mental Health of the decision(s) being appealed (described above). The effective action of the decision(s) being appealed shall not be stayed during the appeal process except at the discretion of the Executive Director.

b. The written notice of appeal must have as its first line of text Notice of Appeal in bold 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) imposed by the Department of Mental Health under appeal; and
(2) A statement of the relief requested.

d. The Executive Director will forward the appeal to 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 ten (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 ten (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 ten (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 and addressed to 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 DMH, 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
(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 must be resubmitted to DMH for review and consideration.

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

I.H.4. DMH waivers are time-limited for the time designated at the time the waiver is granted or a maximum of one (1) year.

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 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/Surrender of Certificate(s)

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 removed from the site and returned to the DMH within fifteen (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 DMH 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 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 to the DMH 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

i. 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:

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 DMH. Technical assistance is not limited to, but may consist of contacts between DMH staff and the program staff via written correspondence, phone consultation, and/or personal visit(s).

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 DMH'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.

I.L.4. Visits to sites may be unannounced.

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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 and comply with 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 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
(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)

e. Disaster preparedness and response plan.

II.A.5. All certified providers must have a written process for meaningful individual and family involvement in service system planning, decision making, implementation and evaluation. Individuals should be provided the opportunity for meaningful participation in planning at least for their_service area.

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.

SECTION B- POLICIES AND PROCEDURES MANUAL

II.B.1. The provider must have and comply with written Policies and Procedures Manual(s) which addresses all sections and standards in Parts II-VII and for all services provided in Parts VIII-XIX, These written policies and procedures must give details of provider/agency implementation and documentation of the DMH Operational Standards for MH/IDD/SA Community Service Providers so that a new employee or someone unfamiliar with the operation of the program would be able to carry out the duties and functions of their position and perform all operations required by the organization, its services and 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

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 Service 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 geographic 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.
(6) The provider must have a method to determine individual satisfaction with each service he/she receives. These evaluations must be conducted at least annually. The method of survey, the evaluation tool, and the results must be on file for review.

For Other Community Service Providers:

(7) 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
(8) Funding for service components at current performance levels by major funding source (federal, state, local)
(9) 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
(10) Brief narrative substantiating targeted performance level on outcome measure, clearly noting any increase, decrease or maintenance in current performance levels
(11) Projected funding by major funding source (federal, state, local) for implementation of each service component at targeted performance levels or outcome measure levels.
(12) The provider must have a method to determine individual satisfaction with each service he/she receives. These evaluations must be conducted at least annually. The method of survey, the evaluation tool, and the results must be on file for review.

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 provider will be put on probation. The DMH will include in the Report of Review of the Annual Operational Plan notification of the disapproval and any required 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 written 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 written 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.

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PART III

FISCAL MANAGEMENT

III.FM. All DMH funded 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
(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 Administration 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.

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, 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

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

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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-L, 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 certified and/or funded by the Mississippi DMH must comply with any additional specifications set forth in individual program grants/contract as well as with the requirements outlined in the DMH Record Guide.

IV.A.3. Providers must maintain current and accurate data for submission of all reports and data, within established time frames, as required by the DMH according to the DMH Manual of Uniform Data Standards.

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 Operational Standards 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.

IV.B.3. All of the following must be documented to support eligibility for BIDD programs:

a. ID/DD Waiver Services: (1) The person meets the criteria for the level of care found in an intermediate care facility for the mentally retarded (ICF/MR), as determined by the Diagnostic and Evaluation Team at one of the state's five (5) comprehensive regional centers and (2) is eligible for Medicaid through one of the categories specified in the federally approved ID/DD Waiver application; **or**

b. Other BIDD Services: Meets the requirements for a certificate of developmental disability as defined in the Developmental Disabilities Assistance Act.

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 and 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
(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.

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 of service and/or when the program is available

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

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

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 activities and experiences to develop the skills they need to support a successful transition to a more integrated setting, level of service, or level of care.

IV.E.4. The services provided as specified in the Individual Service Plan must be based on the 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. In the event that it is determined that an individual's behavior and/or actions are putting other individuals receiving the service at risk for harm (whether physical or emotional), the development of the Behavior Support Plan is not required. The behavior and/or action that warranted discharge 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.

IV.E.8. 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.

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

c. Assurances that DMH Operational 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 other drug disorders 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

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

IV.H.2. 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.3. All entries in individuals' records 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.4. No information in an individual's record shall contain the name or other identifiable information of another individual receiving services.

IV.H.5. Individual records must be closed when there has been no contact for a twelve (12) month period. For alcohol and other drug disorders services records, the case must be closed when no contacts are recorded for ninety (90) days.

IV.H.6. A record must be maintained for all individuals served and must contain (when applicable) the following information:

a. Face Sheet or Identification Data Form

b. Initial Assessment

c. Individual Service Plan, Service/Activity Plan, Needs Assessment/Aftercare Plan, or Plan of Care, depending on service specific requirements

d. Case Management Service Plan

e. For individuals receiving alcohol and other drug disorders 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 Programs.

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

g. Progress Notes and/or Contact Summaries

h. Medication/Drug Use Profile

i. Transfer/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/or 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 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.2(l).
(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.

q. For persons served in any residential program:

(1) Residential Visitation/Telephone Agreement
(2) Medical Screening Report.

IV.H.7. 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.

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 (MS Code Annotated 41-4-7(c)).

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

d. For individuals receiving Individual Therapeutic Support or Acute Partial Hospitalization/Acute Community Stabilization Services, 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.8. 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 within thirty (30) days after Initial Assessment and at least every twelve (12) months thereafter.

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

c. For children and youth admitted to mental health services, one of the following must occur:

(1) If a child/youth has been evaluated by the school district or other approved examiner to determine the need/eligibility for special education services, the mental health service provider must document their request and/or receipt of such evaluation results, provided that appropriate written consent was obtained from the parents/legal 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 Initial Assessment process and/or of the next occurring Individual Service Plan review.

(2) If a child does not have an evaluation as described in IV.H.8.c.(1), the mental health center must administer an instrument approved by the DMH Division of Children and Youth.

d. For individuals with IDD who have been evaluated by one of the five (5) Diagnostic and Evaluation Teams, by a school district or by another approved examiner to determine the need for/eligibility for ICF/MR level of care, special education, and/or a Certificate of Developmental Disability, the evaluation(s) must be maintained in each individual's record as part of the Initial Assessment process.

e. For children/youth admitted to Outpatient Mental Health Services, a functional assessment in addition to the Global Assessment of Functioning (GAF) must be conducted between thirty (30) days and sixty (60) days after Initial Assessment and at least every twelve (12) months thereafter.

IV.H.9. Therapeutic activities provided to individuals receiving services must be documented in individualized Progress Notes/Contact Summaries, which at a minimum include the following elements:

a. A summary of the therapeutic activities of each contact

b. 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

c. A statement of immediate plans for future therapeutic activities.

d. The date, type of service being rendered, and the length of time spent in providing the service.

Alcohol and Other Drug Disorders Services

IV.H.10. 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 Risk 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 the assessment(s) was administered, with documentation of follow-up of results if applicable, in a primary treatment program completed within the last thirty (30) days.

(2) For Outreach/Aftercare Services - The Assessment/Educational Activities Documentation Form (or a copy) is in the individual's

case record verifying that both risk assessment(s) was 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; and
(e) Specific DUI Outpatient Treatment Tracks.

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

(a) General Outpatient Services; and
(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.11. In addition to the Initial Assessment, a DUI Diagnostic Assessment for individuals in the DUI program for second and subsequent offenders must contain the following information:

a. A motor vehicle report (or evidence of a written request) which is obtained by the service provider from the Department of Public Safety. This record must contain:

(1) Previous DUI's
(2) Moving violations.

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

IV.H.12. Providers of Detoxification Services must maintain documentation of hourly observation of the individual receiving services during the first twenty-four

(24) hours of the detoxification program and every two (2) hours during the following twenty-four (24) hours, and as needed thereafter, when medical or social detoxification is prescribed by a physician.

IV.H.13. Providers of Transitional Residential Services must provide in the case records weekly documentation which addresses employment, vocational training, and/or academic activities.

IV.H.14. 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 people receiving services, the following staff to individual ratios apply:

(1) 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)

(2) If there are six (6) individuals on the van, the driver is the only staff person required if no one is medically fragile or uses a wheel chair. If any one of the six people is medically fragile (e.g., prone to frequent seizures, etc.) or use a wheelchair as his/her primary means of mobility, there must be at least the driver and one other staff person on the van.

(3) If there are 7-12 individuals on the van, there must be the driver and one (1) other staff person (except as stated above)

(4) If there are 13-18 people on a bus/van, there must be the driver and two (2) other staff, based on individual need.

(5) If there are 19 or more people on a bus, there must be the driver and three (3) other staff people, based on individual need.

c. 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, first aid tape, nonprescription pain relief tablets, sterile pads, antiseptic wipes, oval eye pads, and a first aid booklet. Medications must not be expired.

f. All vehicles must have liability insurance unless otherwise 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.

IV.I.2. Providers that provide transportation must have policies and procedures in place to protect the safety and well-being of individuals being transported. Policies and procedures must address, at a minimum:

a. Accessibility based on the individuals' needs and reasonable requests

b. Accounting of individuals entering and exiting the provider/program vehicle

c. Availability of communication devices (i.e. cell phones, 2-way radios,etc.)

d. Availability of a vehicle maintenance log for all vehicles used to provide transportation

e. Course of action when staff is unable to leave individuals at home or an alternate site as specified by family/legal guardian that ensures the safety of individuals at all times.

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.

IV.J.2. Transporting and delivery of medications must follow any rules, regulations, guidelines, and statutes set forth by governing bodies authorized to do such.

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 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 must 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 in the governing body minutes.

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 must be documented and approved by the agency's governing body. Any revisions must be communicated in writing to all staff.

IV.K.7. All community residential programs must maintain current 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 must 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.

SECTION L – SERVICE OUTCOME MEASURES

IV.L.1. At a minimum, at least one outcome measure must be established for each service for which a provider is certified.

IV.L.2. Outcome measures must address the key success indicator(s) for a service and be based on a clinical or professionally recognized definition of the service, expert opinion, provider experience, and literature review.

IV.L.3. Providers must describe the data collection/evaluation system that will be used to document the progress made in meeting established outcome measure(s).

IV.L.4. Outcomes measures must be compatible with the intent of the service for which DMH provides certification and must be approved by DMH prior to implementation.

IV.L.5. Outcome measure(s) for each service for which a provider is certified must be included with the provider's Annual Operational Plan as required in II.C.1. The provider must evaluate and report the results of the outcome measure(s) in the subsequent year's Annual Operational Plan.

IV.L.6. Data or evidence being collected to measure outcomes must be available for review by DMH.

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 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. MCA 41-21-102 (7) does allow for restriction to access to records in certain circumstances where it is medically contraindicated.
(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

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

V.A.2. Providers who utilize the following techniques 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. A mechanical restraint is the use of a

mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

b. Providers are prohibited from the use of seclusion except for certified Crisis Stabilization Units (Standards XI.J.29 through XI.J.31). Seclusion means a behavior control technique involving locked isolation. Such term does not include a time-out.

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

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, implement, and comply with 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. The definitions must state, at a minimum:

(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.II.) 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 (30) 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 (24) 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 (1) 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 (60) 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.

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 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. 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.14. 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.15. 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.

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 must focus on the population being served but can include other related areas for broadened understanding. Training must include, but is not limited to:

a. The effects of stigma

b. Developing empathy

c. Nondiscrimination

d. 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, the governing authority and all staff members and volunteers (regardless of whether they hold a professional license) must adhere to the highest ethical and moral conduct in their interactions with the individuals and family members they serve, as well as in their use of program funds and grants. Examples of breeches of ethical or moral conduct toward individuals, their families, or other vulnerable persons,

include but are not limited to, the following situations from which a provider is prohibited from engaging in:

a. Borrowing money or property

b. Accepting gifts of monetary value

c. Sexual (or other inappropriate) contact

d. Entering into business transactions or arrangements. An exception can be made by the Executive Director of the certified provider. The Executive Director of the certified provider is responsible for ensuring that there are no ethical concerns associated with the hiring and supervision practices.

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

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

m. Breech of and/or misuse of confidential information.

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 with limited English proficiency. These services must be offered at all points of contact with the individual while he/she is receiving services.

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, at a program-sponsored event, or at any time during the provision of services 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 (5) working days of the incident. If a final resolution has not been reached within 5 working days, the provider must submit the report as required with as much information as is available. The provider must also submit documentation regarding the final resolution when the information is available.

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 twenty-four (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 Report form within twenty-four (24) hours.

NOTE: This list is not intended to be exhaustive. Programs must use professional judgment. 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 informational poster containing procedures for filing a grievance or complaint with DMH. The information provided by OCS must be posted 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 provider.

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 initially filed with the DMH.

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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 a valid driver's license for all designated drivers

d. 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 must be fingerprinted.

SECTION C- QUALIFICATIONS

VI.C.1. To ensure initial and continuing receipt of certification/funding from the DMH or other approved sources, the provider must maintain documentation that staff meet the following qualifications unless otherwise specified herein:

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 ID/DD 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 either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served).

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 Services, Day Services-Adults, Psychosocial Rehabilitation/Clubhouse Services, Day Support Services etc., must have at least a Bachelor's degree in a mental health, intellectual/developmental disabilities, or a related field, and be under the supervision of an individual with a a Master's degree in mental health or intellectual/developmental disabilities, or a related field and who has either (1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served.

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

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 Nurse Practice Act and Rules and Regulations.

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 in mental health or intellectual/developmental disabilities, or a related field and who has either_(1) a professional license or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist (as appropriate to the 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 or (2) a 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 Mental Illness Management Services (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 a 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 or (2) a DMH credential as a Mental Health Therapist or Intellectual/Developmental Disabilities Therapist, as appropriate to the population being served.

m. Staff providing Individual Therapeutic Support Services must complete training in crisis intervention and behavior management such Mandt Training or Crisis Prevention Institute (CPI). Documentation of training must be maintained in each person's training record.

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

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

p. All staff providing Peer Support Services (i.e. Peer Specialist) must possess at least high school diploma 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 within the last year, or self identify as first degree family member. All staff must successfully complete the DMH approved Certified Peer Specialist training and certification exam.

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

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

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

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

a. Behavior Support Interventionist(s) who conduct evaluations and develop positive 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 Master's degree or higher in a related field such as special education or psychology; AND

(4) Have four (4) years of documented experience developing and implementing positive Behavior Support Plans 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 Certified Social Worker; or,
(3) Have at least a Bachelor's degree in a related field such as special education or psychology; and
(4) Have two (2) years of documented experience implementing positive Behavior Support/Intervention plans 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 Treatment/Rehabilitation Services.

a. Directors of Alcohol and Other Drug Disorders residential programs for adults must have at least: (1) A Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field (2) a professional license or hold a DMH credential as a Certified Mental Health Therapist or DMH Certified Addictions Counselor and (3) two (2) years of experience in the field of alcohol and other drug disorders treatment/prevention. Staff who are in recovery from chemical dependency must have a minimum of one (1) year of recovery.

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 recovery is required.

c. Support staff employed in Alcohol and Other Drug Disorders Residential Programs who are in recovery must also have a minimum of six (6) months of recovery.

d. Alcohol and Other Drug Disorders 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 recovery is required.

e. Alcohol and Other Drug Disorders 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 recovery is required.

f. Alcohol and Other Drug Disorders Outpatient Therapists/Counselors, including Intensive Outpatient Treatment Therapists, must have at least a Master's degree in mental health or intellectual/developmental disabilities or a related behavioral health field and a (1) professional license or (2) hold a DMH credential as a Certified Mental Health Therapist or DMH Certified Addictions Counselor. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of recovery is required.

g. All IOP Counseling Staff must have at least a Bachelor's degree in mental health or a related behavioral health field. For individuals who are in recovery from chemical dependency, a minimum of one (1) year of recovery is required.

h. All aftercare workers must all aftercare workers must have at least a high school diploma or equivalency. These individuals must also successfully complete an alcohol and other 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 of recovery is required. *(See also j. that follows.)*

i. Alcohol and Other Drug Disorders Chemical Dependency Unit and Residential Program counseling staff must have at least a high school diploma or equivalency and Bachelor's degree in a mental health or a related behavioral health field. These individuals must also successfully complete an alcohol and other drug disorders 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 recovery is required. *(See also j. that follows.)*

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

alcohol/drug Residential Treatment Service 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.5.b) 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 diploma 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 diploma 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. CMHC 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. This person must have administrative authority and responsibility for children's mental health services. This person cannot have any direct service responsibilities.

VI.C.7. Unless otherwise specified herein, all individuals employed on and after the effective date of these standards must meet all of the minimum qualifications listed below for providers of Peer Support Services:

a. Individuals must be a current or former consumer or first degree family member of an individual who has received treatment for and self-identifies as a consumer or former mental health consumer.

b. Individuals must possess a high school diploma or GED equivalent.

c. Individuals must have demonstrated a minimum of 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 who works 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;

d. 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 a General Orientation program developed by the agency. General orientation must be provided within thirty (30) days of hire/placement, except for direct service providers and direct service interns/volunteers. All direct service staff must receive training prior to contact with individuals receiving services.

VI.D.2. General Orientation must consist of a minimum of four (4) hours of training. 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

(2) CPR

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

(4) 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/Cultural Issues and 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 a Staff Training Plan for both initial training and required annual training which is specific to each position classification as listed below. Each Staff Training Plan must be based on job responsibilities, program/position requirements, and identified staff needs. The Staff Training Plan must be reviewed annually for changes and/or updates and should be available for review by DMH staff. Position specific training must be provided within ninety (90) days of hire and consist of a minimum of twenty (20) hours of training (medical personnel excluded). The following position classifications must be addressed:

a. Direct service provider (i.e., therapist, case manager, program assistants)
b. Administrative/support staff (i.e., office manager, medical records technician, housekeeper, accounting staff)
c. 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 must be reviewed annually for changes and/or updates and must be available for review by DMH Staff.

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, 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 Operational 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 training and/or personnel records. This documentation must include:

a. Name of training
b. Instructor's name and credentials
c. Date of training
d. Length of time spent in training
e. Topics covered
f. 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. An established method of annual fire equipment inspection.

f. Evidence that fire extinguishers are being recharged or replaced, as needed, but at a minimum every six (6) years.

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; and

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 an inspection schedule; and the temperature measurement must be entered into a log and signed and dated by the person making the entry.

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, including the date of the test and the signature of the person conducting the test.

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

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 that will allow the door to unlock in an emergency.

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 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 Services). 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 (with the exception of CSUs).

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, first aid tape, nonprescription pain relief tablets, sterile pads, antiseptic wipes, oval eye pads, and a first aid booklet. For buildings housing more than one program, a single first aid kit may be used by all programs, if readily/easily accessible for all individuals in the building.

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 and the plan must be available for DMH review.

VII.ES.28. DMH may require additional square footage in any program in order to accommodate the needs of the individuals in the program.

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PART VIII

EMERGENCY/CRISIS SERVICES

VIII.ECS. Emergency/Crisis Services are those designated for immediate intervention(s) available to individuals experiencing personal crisis and/or behavioral needs. 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. Emergency/Crisis Services must be made available in every county/area served by the provider.

VIII.A.3. Recipients of Emergency/Crisis Services do not have to be currently/previously enrolled in any of the services provided by the Community Mental Health Center.

VIII.A.4. 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. This number must be provided to the DMH, Office of Constituency Services. Individuals in crisis should only have to dial a single phone number for assistance. Answering services are permissible as long as the individual speaks with a trained professional. Answering machines are not permissible.

VIII.A.5. Face-to-face contact (i.e. Mobile Crisis Response) with a mental health professional twenty-four (24) hours a day, seven (7) days a week must be available. The staff person is not required to see the individual in the individual's home, but this is permissible and recommended. There must be designated, strategic, publicized locations where the person can meet with a

mental health professional. The individual must be seen within one (1) hour of initial time of contact if in an urban setting and within two (2) hours of initial time of contact if in a rural setting.

VIII.A.6. Appointments for individuals whose crisis is resolved over the telephone must be scheduled the next day, twenty-four (24) hours a day, seven (7) days a week.

VIII.A.7. Assessment and treatment for individuals held in jail/youth detention centers who are waiting for bed availability after an inpatient commitment, must be available twenty-four (24) hours a day, seven (7) days a week.

VIII.A.8. All persons involved in the provision of Emergency/Crisis Services must receive training in the handling of mental health related emergencies and crisis intervention. (See Standard VI.D.5.a.)

VIII.A.9. 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 Examinations.

VIII.A.10. The provider must have obtain and renew annually a 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.11. If a DMH-certified Crisis Stabilization Unit is available in the area, the CMHC must obtain and annually renew a 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.12. Emergency/Crisis service availability must be publicized, including a listing in the telephone directories for each county served by the CMHC.

VIII.A.13. 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 the individual and/or family member/legal guardian contacted the provider

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

d. The location of contact, if it was face-to-face

e. Presenting problem(s)

f. Action(s) taken by emergency services staff

g. Documentation of notification and involvement of significant others, and if contact is deemed inappropriate, indication of why there was no notification

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
(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 FOR CHILDREN AND YOUTH

VIII.B.1. Intensive Crisis Intervention Services for Children and Youth are specialized, time limited interventions that last for 6-8 weeks and include intensive outpatient mental health therapy services and in-home services and support for the family or other caregivers. These services are available twenty-four (24) hours a day, seven (7) days/week.

VIII.B.2. Providers of Intensive Crisis Intervention Services, must also comply with Emergency/Crisis Services standards (Part VIII, Section A).

VIII.B.3. Providers of Intensive Crisis Intervention Services must, at a minimum, provide access to Case Management and Outpatient Mental Health Therapy Services.

VIII.B.4. Providers must include documentation in the child/youth's record that he/she has entered Intensive Crisis Intervention Services and must have a plan in place for transition out of intensive crisis intervention services.

SECTION C- ACUTE PARTIAL HOSPITALIZATION/ACUTE COMMUNITY STABILIZATION SERVICES

VIII.C.1. Acute Partial Hospitalization/Acute Community Stabilization (APH/ACS) Services provide medical supervision, nursing services, structured therapeutic activities and intensive psychotherapy (individual, family and/or group) to individuals who are experiencing a period of such acute distress that their ability to cope with normal life circumstances is severely impaired. APH/ACS Services are designed to provide an alternative to inpatient hospitalization for such individuals or to serve as a bridge from inpatient to outpatient treatment. Program content may vary based on need but must include close observation/supervision and intensive support with a focus on the reduction/elimination of acute symptoms. APH/ACS Services 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. The APH/ACS program must be a part of a written comprehensive plan of crisis stabilization (as described in Part VIII.ECS) and community support services that includes, at a minimum, family interventions, Intensive Case Management Services, medication monitoring, and other community support activities. The APH/ACS 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.3. There must be written policies and procedures implemented for providing APH/ACS 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.4. The staff for APH/ACS Services must include at each site a full time director who plans, coordinates, and evaluates the program.

VIII.C.5. APH/ACS Services 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. The staff can be the on-site Program Director if he/she is actively engaged in programmatic activities with individuals during all program hours.

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.6. The APH/ACS Program must provide adequate nursing and psychiatric services to all individuals served. At a minimum, these services must be provided weekly (and more often if clinically indicated). Provision of these services must be documented through an implemented written procedure carried out by the CMHC or through contractual agreement.

VIII.C.7. The APH/ACS 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.

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

VIII.C.8. The APH/ACS Program must be designed for a maximum number of eighteen (18) individuals with a maximum length of stay of thirty (30) service days. Service in the APH/ACS 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 DMH Review Committee must be included in the individual's record.

VIII.C.9. The provider must maintain a daily schedule of therapeutic activities to include individual, group, family, and other activities.

VIII.C.10. 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 as a minimum required service 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. School Based Services, Mental Illness Management Services (MIMS) and Individual Therapeutic Support Services are considered types of Case Management Services but differ from traditional Case Management Services in purpose and scope.

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 eligible for Case Management Services. Individuals seeking mental health services and/or being referred for mental health services must be evaluated for and begin receiving case management services, if they so choose, within fourteen (14) days of the date of the Initial Assessment.

IX.A.2. The following individuals with serious mental illness and children/youth with serious emotional disturbance must be evaluated to determine the need for Case Management Services. Case Management Services must be provided if the evaluation indicates a need for such, unless the individual states, in writing, that he/she does not want to receive Case Management Services.

a. Adults who have a serious mental illness or children/youth with serious emotional disturbance and who are Medicaid eligible

b. Adults with serious mental illness who are 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

d. Children/youth with a serious emotional disturbance who are referred to the Community Mental Health Center after discharge from inpatient psychiatric care, residential treatment, or a therapeutic group home.

IX.A.3. Case Management Services must be offered to individuals with serious mental illness, intellectual disabilities/developmental disabilities, and legal guardians of youth with serious emotional disturbance, at a minimum, every twelve (12) months. If the individual refuses Case Management Services, the refusal must be documented in writing.

IX.A.4. The provider must document the involvement of the individual's family/parents/legal guardian in the development of the Case Management Service Plan and in Case Management Services, when appropriate.

IX.A.5. Providers of Case Management Services must, at a minimum:

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

b. Assign a full time, DMH Credentialed Case Manager for each individual enrolled in Case Management Services.

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. Electronically maintained resource information is permissible. This resource file must include at a minimum:

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

IX.A.6. If a Case Manager is unable to contact someone for twelve (12) months, the case must be closed. All efforts to contact the individual must be maintained in the individual's record.

SECTION B- CASE MANAGEMENT SERVICES FOR ADULTS WITH SMI

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

IX.B.1. Providers must adhere to the following case load requirements:

a. Regular case load: Maximum of forty (40) individuals

b. Combination case load: Maximum of no more than twenty (20) regular and forty (40) follow-along individuals

c. Follow-along only: Maximum of eighty (80) individuals.

IX.B.2. Providers must utilize the following framework to support the frequency of Case Management Services contacts:

a. High – At least one (1) time per week

b. Moderate – At least two times per month

c. Low – At least one time per month

d. Follow Along – at lease once every three (3) months

IX.B.3. The Case Management Service Plan must clearly state and justify the frequency of contact.

SECTION C- CASE MANAGEMENT SERVICES FOR CHILDREN/ YOUTH WITH SED

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. The case manager must document all efforts to include the following representatives in the development of the Case Management Service Plan:

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 from the parent(s)/legal guardian(s) in the development of the Case Management Service Plan for children/youth must be documented.

IX.C.3. 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 of referral to the CMHC.

IX.C.4. The case load for a single Case Manager must not exceed fifty (50) children/youth. This includes combined case loads of SMI/SED. The case load for a single case manager providing services to children, youth, and transition-age youth enrolled in federal System of Care grants must not exceed twenty-five (25).

SECTION D- CASE MANAGEMENT SERVICES FOR INDIVIDUALS WITH INTELLECTUAL/DEVELOPMENTAL DISABILITIES

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 requirements:

a. High- Maximum of forty (40) individuals

b. Moderate – Maximum of sixty (60) individuals

c. Low – Maximum of eighty (80) individuals;

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

IX.D.3. Providers must utilize the following framework to support the frequency of Case Management Services contacts:

a. High- one (1) to four (4) times per month;

b. Moderate – One (1) time every one (1) to three (3) months

c. Low – One time every three (3) months to one (1) time per year.

IX.D.4. Potential/Temporary Case Management Services can be provided to individuals with documented need while they are in the process of being enrolled in permanent Case Management Services or to individuals who do not need ongoing Case Management Services 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 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. Individuals receiving School Based Services must meet eligibility requirements for one or more of the following service categories:

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

b. Children/youth with intellectual/developmental disabilities.

IX.E.5. It is not necessary that a child/youth be receiving traditional Case Management Services in order to receive School-Based Services.

IX.E.6. 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.7. 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.8. 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.9. 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.10. 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.6.

IX.E.11. 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 MANAGEMENT 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 or and IDD children or adults with SMI and/or IDD 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 provider must develop and implement written policies and procedures for providing MIMS that must at a minimum:

a. 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.

b. Describe how MIMS is coordinated with other Case Management Services, Crisis Services, and other community support system activities.

c. Defines the credential (Master's degree-see Standard VI.C.1 (l)) of the direct service provider.

IX.F.4. The MIMS Program Director and a licensed physician, a licensed psychologist, or psychiatric/mental health nurse practitioner must certify the necessity of treatment and the appropriateness of care with a signature and date on the Individual Service Plan.

IX.F.5. 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 required signatures on the Individual Service Plan.

IX.F.6. MIMS Program Directors must have (1) administrative experience; and (2) meet requirements as outlined Standard VI.C.1.

IX.F.7. The Individual Service Plan must address needs for intensive services identified in the Initial 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.8. The program must have a process for the evaluation of the individual at least every six (6) months to determine the individual's readiness to transition out of MIMS.

IX.F.9. A Transfer/Termination Summary for closed cases must be maintained in the case record, as described in Standard IV.H.6(i), including staff responsible for continuation of services included in the Discharge Plan.

IX.F.10. 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. 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.3. 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 be credentialed as a DMH Mental Health or IDD Therapist.

IX.G.4. Staff providing Individual Therapeutic Support Services must have a high school diploma or a GED and documentation of required training. (See VI.C.1.m.)

IX.G.5. 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.6. 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 Services.

IX.G.7. The need for Individual Therapeutic Support Services must be justified in the person's Individual Service Plan.

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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 Services are 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. The Psychosocial Rehabilitation/Clubhouse must operate in one location for a minimum of four (4) hours per day, four (4) days per week, excluding travel time.

X.A.3. A Psychosocial Rehabilitation/Clubhouse program must have an annual average daily attendance of more than eight (8) individuals.

X.A.4. All activities of the Psychosocial Rehabilitation/Clubhouse must be established around a work-ordered day structured by task activity units. The work-ordered day must exclude outside interruptions and activities. All individuals/members must be given an opportunity to participate in all units.

X.A.5. 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.6. Transitional, supported and independent, employment opportunities must be an integral part of Psychosocial Rehabilitation/Clubhouse Services and must be available to at least 10% of the number of partcipants the program is certified to serve.

X.A.7. 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. Transitional employment placements must be part-time and time-limited, generally fifteen (15) to twenty (20) hours per week and six (6) to nine (9) months in duration.

X.A.8. Recreational and social activities must also be offered during evening hours and/or on weekends to further develop relationships and interactions. However, recreational and/or social activities must not be conducted during the structured program hours.

X.A.9. The Psychosocial Rehabilitation/Clubhouse must have its own identity, including its own name.

X.A.10. The Psychosocial Rehabilitation/Clubhouse must 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 Psychosocial Rehabilitation/Clubhouse 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. 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 (1) 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.

X.A.19. The program must be voluntary and must be available to individuals ages eighteen (18) and older who have a serious mental illness unless that person poses a significant or current threat to the general safety of the Clubhouse community.

X.A.20. All staff members must receive training on Psychosocial Rehabilitation/Clubhouse policies and standards prior to service delivery. The training must be documented.

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. Senior Psychosocial Rehabilitation Services 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.3. No individuals under fifty (50) years of age can be considered for Senior Psychosocial Rehabilitation Services. 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.4. Senior Psychosocial Rehabilitation programs must have and average daily attendance at least five (5) individuals**.**

X.B.5. For programs located in a CMHC, the service must be provided in each location a minimum of three (3) days per week for a minimum of four (4) hours per day**,** excluding travel time**.**

X.B.6. 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.7. Each Senior Psychosocial Rehabilitation site must have a written schedule of daily activities on file, which must include individual therapy, group therapy, family therapy, socialization activities, activities of daily living, and recreational activities.

X.B.8. Senior Psychosocial Rehabilitation Services must have activities and physical surroundings that are age appropriate.

X.B.9. The 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 usable space for each individual.

X.B.10. Staff must be assigned full time to Senior Psychosocial Rehabilitation Services.

X.B.11. There must be a full time supervisor **(**as defined in Standard VI.C.1 (c)) at each site who plans, coordinates, and evaluates the service.

X.B.12. Senior Psychosocial Rehabilitation Services staffing patterns must meet the following minimum requirements:

For programs located in a Community Mental Health Center:

a. There must be at least one staff member with minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who must be on-site and be actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor.

b. The staff person with a Bachelor's (who must be on-site and actively engaged in program activities during all programmatic hours and who may or may not be the on-site supervisor) is required for eight (8 or fewer people.

c. When the program is certified for nine (9) or more people, there must be another staff person for every 8 (eight) individuals.

For programs located in a nursing home:

d. There must be at least one staff member with minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who must be on-site and be actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor.

e. The staff person with a Bachelor's (who must be on-site and actively engaged in program activities during all programmatic hours and who may or may not be the on-site supervisor) is required for six (6) or fewer people.

f. When the program is certified for nine (9) or more people, there must be another staff person for every six (6) individuals for which the program is certified to serve.

X.B.13. All individuals admitted to Senior Psychosocial Rehabilitation Services must have a medical screening by a licensed physician or certified nurse practitioner, including a statement from the examiner which verifies the individual is free from disease and does not have any health condition that would create a hazard for other individuals or employees of the service. The result of the examination is to be placed in each individual's record. No one will be admitted to or retained in the Senior Psychosocial Rehabilitation program without such required documentation. This screening must be completed within seventy-two (72) hours of admission but no earlier than thirty (30) days prior to admission.

SECTION C- DAY SUPPORT (PSYCHOSOCIAL REHABILITATION) SERVICES

X.C.1. Day Support Services 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. 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

l. Assistance with improving physical and emotional well being.

X.C.3. 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. Adults with a substance abuse diagnosis and with a history of substance abuse.

X.C.4. 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.5. 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.6. 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.7. 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.

X.C.8. For every twelve (12) individuals served, there must be at least one (1) staff person actively engaged in program activities during all programmatic hour. The staff person may be the on-site supervisor.

SECTION D- DAY TREATMENT SERVICES

X.D.1. Day Treatment Services are the most intensive outpatient services available to children/youth. The services must provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment Services are a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which provides 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. Day Treatment Services are 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 at a particular site and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution.

The Standards that follow pertain to ALL providers and all types of Day Treatment Services.

X.D.2. Children/youth must have the following in order to receive Day Treatment Services.

a. An eligibility determination for one of the following: Serious Emotional Disturbance, Autism Spectrum Disorders, Fetal Alcohol Spectrum Disorder, Alcohol and Other Drug Disorders, Intellectual/Developmental Disabilities.

b. A justification of the need for Day Treatment Services which must include documentation of the intensity and duration of problems, as part of the Initial assessment or as part of a post-intake case staffing and at least annually thereafter. Documentation must also include the identification of at least three (3) specific behavioral criteria as set forth by DMH whose severity would prevent treatment in a less intensive environment.

X.D.3. Children must be between the ages of 3-21 to be considered for enrollment in Day Treatment Services.

X.D.4. Each individual Day Treatment program must operate at a minimum of two (2) hours per day, two (2) days per week up to a maximum of five (5) hours per day, five (5) days per week. Each child/youth enrolled in Day Treatment Services must receive 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.5. To ensure each child's confidentiality, no children other than those enrolled in Day Treatment Services can be present in the room during the time Day Treatment Services are being provided.

X.D.6. Only one (1) Day Treatment Services program is allowed per room during the same time period.

X.D.7. Each individual Day Treatment Services program must operate under separate DMH Certificates of Operation.

X.D.8. The Day Treatment Services 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 Services Director or their designee must provide at least thirty (30) continuous minutes of direct observation to each individual Day Treatment Services program at least quarterly. Documentation of the supervision/observation must be maintained for review.

X.D.9. The DMH Division of Accreditation and Licensure must be notified immediately of any interruption of service with an individual Day Treatment program extending over thirty (30) days. If operation has been interrupted for sixty (60) calendar days, the DMH Certificate of Operation for that individual program must be returned to the DMH Division of Accreditation and Licensure.

X.D.10. Day Treatment Services are intended to operate year-round and can not be designed to operate solely during the summer months.

X.D.11. Day Treatment Service programs that are unable to provide services during a school's summer vacation will be allowed to hold that individual program's Certificate of Operation until it can be reopened the following school year. If the program has not reopened within sixty (60) calendar days from the first day of the school year, the Certificate of Operation must be returned to DMH Division of Accreditation and Licensure.

X.D.12. Individual Day Treatment Service programs that do not meet during summer vacation must offer services (i.e. case management, outpatient therapy, etc.) for the child/youth to the parent(s)/legal guardian(s) for the period Day Treatment Services are temporarily not in operation. Documentation must be maintained in each child/youth's record that availability of other services was explained and offered to the parent(s)/legal guardian(s).

X.D.13. Individual Day Treatment programs operated in a school must ensure that Day Treatment Services continue to adhere to all DMH Operational Standards for MH/IDD/SA Community Service Providers for this service. Day Treatment Services are a separate program from educational programs which must meet applicable State Department of Education standards and regulations. Day Treatment Services and educational services may not be provided concurrently.

X.D.14. Each Day Treatment program must be designed and conducted as a therapeutic milieu as evidenced by the use of a curriculum approved by the DMH and must include, but not be limited to, such skill areas as functional living skills, socialization or social skills, problem-solving, conflict resolution, self-esteem improvement, anger control and impulse control. The approved curriculum must be kept on site. All activities and strategies implemented must be therapeutic, age appropriate, developmentally appropriate and directly related to the objectives in each child/youth's Individual Service Plan.

X.D.15. 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 with the exception of Day Treatment Services for children and youth with alcohol and other drug disorders (see Standard X.D.21).

X.D.16. Each Day Treatment Program (four (4) to nine (9) 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.17. Each Day Treatment Program must comply with the following:

a. A minimum of twenty (20) square feet of usable space per child

b. In cases of programs located in a school, the mental health provider is responsible for ensuring that the school district provides a site or facility that meets all 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 Program environment must be age-appropriate, developmentally appropriate, and therapeutic in nature.

X.D.18. The ratio of staff to children/youth receiving services in each Day Treatment Program will be maintained at a minimum ratio of two on-site persons for a minimum of four (4) up to a maximum of nine (9) children/youth per program. Each 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(q)) serve as the second needed staff in this ratio.

X.D.19. For all children/youth participating in Day Treatment Programs, there must be documentation of plans for transitioning a child to a less intensive therapeutic service when deemed clinically appropriate. This documentation must be documented in each child's Individual Service Plan in his/her record.

Day Treatment Services for Children/Youth with Intellectual /Developmental Disabilities

X.D.20. In addition to meeting all requirements and standards included in Section D (Standards X.D.1 through X.D.19.), providers of Day Treatment Services to children/youth with Intellectual or Developmental Disabilities (ID/DD) must document the justification of the need for Day Treatment Services for children with ID/DD as part of the Initial Assessment. Documentation must include, at a minimum: psychological testing and an 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 Other Drug Disorders

X.D.21. In addition to meeting all requirements and standards included in Section D (Standards X.D.1 through X.D.19), providers of Day Treatment Services for children/youth with alcohol and other drug disorders must operate for at least ten (10) weeks for each child/youth.

X.D.22. The roll/roster cannot exceed twelve (12) children/youth.

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 X.D.1 through X.D.19 for all Day Treatment Services.

X.D.24. All children must be signed in and out of the program by a parent/legal guardian. If a child is being transported by the program staff, the parent/legal guardian must sign when they put the child on and take the child off of 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 record. Sign In/Out documentation must be available for review.

X.D.25. Chairs and tables used in the room where Day Treatment Services are provided must be appropriate to the size and age of the children. This furniture must be kept clean with frequent disinfection.

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 Services must be age-appropriately immunized and must have a Mississippi State Department of Health Certificate of Immunization Compliance on file.

X.D.28. Any child who is suspected of having a contagious condition must be removed from the room where Day Treatment Services are being provided and sent home with their parent/legal guardian as soon as possible. The child will not be allowed to return to the Day Treatment program until they have been certified by a physician as no longer being contagious. Conditions that would require exclusion from the program include fever, diarrhea, vomiting, rash, sore throat if accompanied by a fever, and/or eye discharge.

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.

Day Treatment Services for Children and Youth with SED

X.D.30. 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 each CMHC.

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PART XI

COMMUNITY LIVING

Community Living Services encompass any type of provider managed 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 each individual.

SECTION A- TYPES OF COMMUNITY LIVING SERVICES

XI.A.1. Supported. The provider has necessary staff to support an individual in the community who needs support less than twenty-four (24) hours per day/seven (7) days per week. Supported Living is the most integrated Community Living Service available. Services offered through 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.

b. Therapeutic Foster Care (TFC). These services are only available to children/youth with serious emotional disturbance.

c. Supported Living Services. Supported Living 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.

XI.A.2. Supervised. 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 Services are an intermediate level of Community Living Services. Services offered under Supervised Living include:

a. Supervised Living. This service is available to adults who have IDD and/or SMI.

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 Treatment/Rehabilitation services.

d. Halfway House. 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)

hours a day/seven (7) days per week (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 Treatment/Rehabilitation Services.

c. Primary Residential. This service is available to individuals seeking Substance Abuse Prevention and Treatment/Rehabilitation Services.

d. Crisis Stabilization Units (CSU). This service is available to adults with serious mental illness.

SECTION B- PROGRAM MANUALS

XI.B.1. Providers of all types of Community Living Services must develop a Program Manual which includes all policies and procedures for the service. The Program Manual must be readily available for review by staff and must be updated as needed. At a minimum, the Program Manual must address the following:

a. A person friendly, person first 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 evaluate 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

g. A description of the program rules, to include but not limited to:

(1) Visitation (including family, significant others, friends and other visitors) during reasonable hours
  (a) Individual's right to define their family and support systems for visitation purposes unless clinically/socially contraindicated

(b) All actions regarding visitors (restrictions, defining individual and family support systems, etc.) must be documented in the case record
(c) Any restrictions on visitors must be reviewed at a minimum daily
(d) Visitation rights must not be withheld as punishment.

(2) Daily private communication (phone, mail, email, etc.) without hindrance (unless clinically contraindicated):
(a) Any restrictions on private telephone use must be reviewed daily
(b) All actions regarding restrictions on outside communication must be documented in the case record
(c) Communication rights must not be withheld as punishment.

(3) Dating
(4) Off-site activities
(5) Household tasks
(6) Curfew
(7) Use of alcohol, tobacco and other drugs;
(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. Assisting individuals in arranging and accessing 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. Discharge criteria.

Additionally, Supervised and Residential Living must address:

q. A description of the meals, which must be provided at least three (3) times per day, and snacks to be provided. This must include development of a menu with input from individuals living in the residence that includes varied, nutritious meals and snacks and a description of how/when meals and snacks will be prepared.

r. Personal hygiene care and grooming, including any assistance that might be needed

s. Medication management (including storing and dispensing)

t. Prevention of and protection from infection, including communicable diseases.

u. The agency's policies regarding pets on program property. The policy must address, at a minimum, the following:

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

v. Smoking is not permitted within ten (10) feet of the entrance of a supervised living or residential facility.

SECTION C- SPECIFIC PROGRAM MANUAL REQUIREMENTS FOR COMMUNITY LIVING SERVICES FOR CHILDREN AND YOUTH

XI.C.1. Each child/youth (ages birth up to 21 years) must be enrolled in an appropriate educational program in the local school district or be enrolled in an educational program operated by the provider that meets the individualized educational needs of the child/youth and is accredited by the Mississippi Department of Education.

XI.C.2. All Community Living Services 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
h. Education and counseling about sexually transmitted diseases.

Therapeutic Foster Care:

i. The provider must provide a description of therapeutic modalities and treatment activities (including age-appropriate activities) to be provided (if any) and a schedule of these activities.

Supervised and Residential Living Services

j. 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 Community Living Programs. 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.

k. 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.

l. Children/youth must have a dental examination within sixty (60) days after admission and annually thereafter or have evidence of a dental exam within the last 12 months.

XI.C.3. All programs that provide services for children under the age of eighteen (18) must have on file an assurance signed by the Executive Director of the provider stating compliance with the provisions of Public Law 103-227 (Pro-Children Act of 1994). Note: Providers funded by the DMH must have a current "Certification Regarding Environmental Tobacco Smoke."

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/legal guardian during orientation that addresses all elements of the Program Manual specific to the service being provided.

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.

b. The provider must document input from residents regarding the development of all sections of the handbook.

SECTION E- FEE AGREEMENTS

XI.E.1. In living arrangements in which the residents pay rent/utilities, there must be a written financial agreement which addresses, at a minimum, the following:

a. Procedures for setting and collecting fees (in accordance with Standard III.FM.2.)

b. A detailed description of the basic charges agreed upon (ex: rent, utilities, food, etc.)

c. The time period covered by each charge

d. The service(s) for which special charge(s) are made

e. The written financial agreement must be explained to and reviewed with the individual/legal guardian prior to or at the time of admission and at least annually thereafter or whenever fees are changed

f. A requirement that the individual's record contain a copy of the written financial agreement which is signed and dated by the individual/legal guardian indicating the contents of the agreement were explained to them and they are in agreement with the contents.

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(s) 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 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 an appointment has been secured.

b. The child/youth (and family member(s) as appropriate) are evaluated for, enrolled in, and begin receiving Case Management Services within two (2) weeks after referral for community services.

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

d. Children and youth in the custody of the MS Department of Human Services are provided an opportunity for one pre-placement visit prior to discharge.

e. Documentation that an appointment has been scheduled with the CMHC responsible for services in the county where the child/youth will reside upon discharge.

SECTION G- SUPPORTED LIVING OPTIONS

Supported living options include: Home and Community Supports (HCS) for individuals with intellectual or developmental disabilities, 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 individuals who require assistance to meet their daily living needs, ensure adequate functioning in their home and community, and provide safe access to the community. In addition to Standards XI.G.2-XI.G.7, Standards XI.G.22-XI.G.30 also apply.

XI.G.2. 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

d. Support and assistance for community participation, including appointments, banking, shopping, recreation/leisure activities, socialization opportunities.

XI.G.3. 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.4. 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.5. HCS Staff are not permitted to provide medical treatment as defined in Mississippi Nurse Practice Act and Rules and Regulations. They cannot accompany a minor on a medical visit without a parent/legal guardian present.

XI.G.6. HCS staff may assist individuals with money management, but cannot receive or disburse funds on the part of the individual. Individuals must maintain their own financial resources and there must be implemented policies in procedures in place to ensure the following:

a. No staff or agency name can appear on an individual's personal accounts

b. No financial transaction can be made if the individual is not present

c. The HCS staff person will document the amount of money received and its intended purpose if a family member/legal guardian gives the individual money to spend in the community. The family member/legal guardian must sign the document verifying the amount of money sent with the individual.

d. Upon return home, the HCS staff person gives the family member/legal guardian any receipts for money spent and any change left over. The HCS staff person documents the amount returned on the form indicating he/she agrees with the amount of money returned. The family/legal guardian must sign the document indicating agreement with the amount of money returned and how it was spent.

XI.G.7. HCS provided during overnight hours must be provided in the individual's legal residence. Any exceptions to this standard must be prior approved by the Director of the BIDD.

Therapeutic Foster Care Programs

XI.G.8. 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 licensed foster home.

XI.G.9. 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 all of the following conditions apply:

a. The siblings have never been separated

b. The siblings are not a danger to others

c. The DMH Review Committee given prior approval, in writing, that the siblings may be placed together in the same TFC home. This documentation must be maintained in the individual ~~case~~ record of each sibling

d. Prior to seeking DMH approval, TFC parents asked to place siblings in their home must consent, in advance in writing, to the placement in writing. This documentation must be maintained in the individual record of each sibling.

XI.G.10. 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.11. 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

d. Performance of other family support activities, as needed.

XI.G.12. 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.13. 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.14. 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.15. TFC programs can use only adults with current documentation of foster parent approval from the Mississippi Department of Human Services.

XI.G.16. Each TFC program must have one (1) full-time professionally licensed or DMH credentialed mental health therapist for every twenty (20) foster children/youth in the TFC program. If the TFC program obtains these services through a contractual agreement (see Standard XI.G.14), the TFC programs is responsible for ensuring that this standard is met.

XI.G.17. 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.18. Arrangements must be made for and documentation maintained in the record that the youth has had a physical examination within thirty (30) days after admission, and annually thereafter.

XI.G.19. Arrangements must be made for and documentation maintained in the record that children/youth have a psychological or psychiatric evaluation at least annually.

XI.G.20. The mental health therapist is required to have at least one individual therapy session per week with the child/youth. At least one family session per month

is required with the foster parent(s). If the TFC program obtains these services through a contractual agreement (see Standard XI.G.14), the TFC programs is responsible for ensuring that this standard is met.

XI.G.21. 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 Living Services

XI.G.22. Supported Living Services are provided residences for three (3) or fewer people. Individuals function with a greater degree of independence than in a Supervised Living Services environment. Contacts with the individual must take place on a regular basis, at least one time per week in order to ensure the individual is succeeding in Supported Living Services. During the day individuals may engage in activities of the provider program, supported or transitional employment, competitive employment, or other community activities.

XI.G.23. If the housing complex 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, as needed or, at a minimum, every 6 years (Standard XIII.ES.1.f.);

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.24. 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;

c. Hot water safety. If necessary, staff must assist in testing and regulating the hot water temperature; and

d. Any other health/safety issues based on the needs of each resident.

XI.G.25. Providers who serve individuals who live alone and are not in a Supported Living Services complex 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.26. Providers must develop methods, procedures and activities to provide independent living choices for the individual(s).

XI.G.27. Procedures must be developed for individual(s) to access any other needed services in the event of an emergency.

XI.G.28. To the degree possible, the residents must have the authority and responsibility to maintain their residence as they choose.

XI.G.29. Support must be available as needed to provide, at a minimum:

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 SERVICES

XI.H.1. This section applies to environmental and programmatic requirements that are specific to all Supervised Living and Residential Treatment Services.

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
    (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

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

XI.H.12. All individuals admitted to Supervised Living or Residential Treatment Services 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 Supervised Living or Residential Treatment Services 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.13 The provider must ensure that each individual served in Supervised Living or Residential Treatment Services has appropriate clean, comfortable, well-fitting clothes and shoes.

XI.H.14. The individuals living in Supervised Living and Residential Treatment Programs must be enrolled as receiving services of the program.

XI.H.15. 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.16. The provider must have a full-time site manager for each service site.

XI.H.17. Supervised Living sites must, to the maximum extent possible, duplicate a "home-like" environment.

SECTION I- SUPERVISED LIVING

Supervised Living for Individuals with Intellectual /Developmental Disabilities and SMI

XI.I.1. Supervised Living Services 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. A maximum of six (6) individuals may reside in any single apartment or house.

XI.I.3. 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.4. Supervised Living Services for individuals with an intellectual/developmental disability or SMI can be provided in a home or apartment setting and include the services in XI.1 as well as the following:

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.5. Each person entering Supervised Living Services must participate in an individualized assessment, as indicated in the DMH Record Guide, to be used to develop his/her Individual Service Plan.

<u>Therapeutic Group Homes – Children and Youth</u>

XI.I.6. 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 Facility (PRTF) 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.7. The maximum bed capacity of each TGH is ten (10) beds per home for children and youth twelve (12) years of age through age twenty years and 11 months and eight (8) beds for children and youth ages six (6) years through eleven (11) years and eleven (11) months. The Mississippi DMH may require a lower bed capacity than described in this standard, depending on the age, developmental or level of functioning, or intensity of need for intervention and supervision of the population of children and youth served in the individual home.

XI.I.8. 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.9. 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. In TGH's with five (5) or fewer children or youth, at least one (1) staff member (which can be a direct care worker or house parent) with a least a Bachelor's degree in a mental health or related field must be assigned to direct service responsibilities for the children/youth during all hours

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. Have a full-time director (see requirement Standard VI.C.1.a.) 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

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.10. 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.11. 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.12. 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.13. Transition plans must be developed within ninety (90) days prior to completion of a TGH program and be included in the child/youth's record

<u>Transitional Residential Services – Substance Abuse and Treatment/Rehabilitation</u>

XI.I.14. The Transitional Residential Substance Abuse Treatment and Rehabilitation 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.15. Staffing must be sufficient to meet service requirements. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week.

XI.I.16. An individual must have successfully completed a primary substance abuse treatment program in order to be eligible for admission to transitional residential services. The primary substance abuse treatment program must be at least thirty (30) days long.

XI.I.17. 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.18. Transitional Residential Programs serving pregnant and parenting women/legal guardians with young children who reside on the program site must adhere to the following:

a. Provide adequate, secure, and supervised play space for the children of women served in the program

b. Prohibit any form of corporal punishment by staff or individuals receiving services. Staff must provide residents with information regarding positive approaches to management of their children's behavior.

Halfway House Services – Adults with SMI

XI.I.19. Halfway House Services for adults 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.20. Staffing must be sufficient to ensure program requirements are met. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week.

XI.I.21. The provider of Halfway House Services must have a written schedule of activities and procedures providing access to the following:

(1) At least one hour of individual counseling or two hours of group counseling per week per person
(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 nutritional habits training
(7) Recreation and social activities
(8) Prevocational and/or vocational training
(9) Orientation to community resources.

XI.I.22. 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 Mental Health Services for approval by the DMH Review Committee.

SECTION J- RESIDENTIAL TREATMENT SERVICES

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

XI.J.4. The Residential Treatment Services program must meet licensure and certification requirements 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 Services. 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 children and youth must also meet the standards in Parts VIII, Sections A and B.

XI.J.6. 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.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 DMH Review Committee, 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.8. Children/youth served by the Crisis Program must meet the following eligibility criteria:

a. Be a minimum of six (6) years of age and a maximum of eighteen (18) years of age and within a developmentally appropriate age range to benefit from the services of the program as specified/determined by the program;

b. Be experiencing severe, demonstrable emotional crisis(es) that can be appropriately addressed through the specific services provided by the program and as confirmed by designated staff; and

c. The condition/situation indicates that Crisis Residential Treatment could divert the child/youth from inpatient care or other more restrictive placement.

XI.J.9. Crisis Residential Treatment Programs must provide the following services:

a. Medical and psychological evaluation and assessment by appropriately certified professionals of the need for referral to other specialized treatment programs or services (such as alcohol/drug treatment)

b. Psychiatric consultation

c. Case Management Services

d. Family education and counseling

e. Access to Intensive Crisis Intervention aftercare.

XI.J.10. Children/youth served in a Crisis Residential Treatment Program must, at a minimum, receive an initial individual therapy session within the first four (4) days of admission.

XI.J.11. 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 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.12. The child's/youth's stay in the Crisis Residential Treatment Program must not extend beyond a maximum of twenty-one (21) consecutive days. A request for an extension of this timeframe must be submitted in writing to the Director, Bureau of Community Mental Health Services for approval by the DMH Review Committee.

XI.J.13. 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.8.

Chemical Dependency Unit Services – Substance Abuse Prevention and Treatment/Rehabilitation

XI.J.14. Chemical Dependency Unit Services include inpatient or hospital-based services for individuals with more severe alcohol or other drug disorders and who require a medically-based environment. Treatment usually includes detoxification, group, individual, and family therapy, education services explaining alcohol/drug dependency, personal growth, and the recovery process, aftercare, and family counseling.

XI.J.15. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week.

XI.J.16. 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.17. 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; and

g. For children and youth, the academic schedule indicating school hours.

Primary Residential Services – Substance Abuse Prevention and Treatment/Rehabilitation

XI.J.18. The Primary Residential Substance Abuse Treatment Program is an intensive residential program for individuals who are addicted to or abuse alcohol or other drugs. This type of treatment offers a group living environment in order to provide the individual with a comprehensive program of services that is easily accessible and responsive to his/her needs. Because alcohol and other drug disorders are a multidimensional problem, various treatment modalities can be made available through the program. These include: group, individual, and family therapy; education services explaining alcohol/drug dependency, personal growth, and the recovery process; vocational and rehabilitation services and employment activities; and recreational and social activities. This program facilitates continuity of care throughout the rehabilitation process.

XI.J.19. Programs serving children or youth must also comply with the following Operational Standards Part XI, Section C and Standards XI.I.6 through XI.I.13**.**

XI.J.20. 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.21. Staffing must be sufficient to meet service goals. Staff must be on-site twenty-four (24) hours per day, seven (7) days per week.

XI.J.22. The program must have a written master schedule of activities and must document provision of the following services:

a. At least one (1) hour per week of individual counseling with each individual

b. At least five (5) hours per week of group counseling with each individual

c. Involvement of family by having at least two (2) family therapy sessions available during the course of treatment;

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. At least three (3) hours of family-oriented education activities

f. Therapeutic and leisure/recreational/physical exercise activities (with physician's approval)

g. Vocational counseling and planning/referral for follow-up vocational services

h. For child/youth, the academic schedule indicating school hours.

XI.J.23. 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; and

b. Prohibit 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.24. CSU services are time-limited Residential Treatment 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.

XI.J.25. 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 Director, Bureau of Community Mental Health Services and the DMH Review Committee 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.26. The CSU must have a full-time director.

XI.J.27. All providers of CSU services must develop policies and procedures which, at a minimum, address the following:

a. Requirement for emergency admissions twenty-four (24) hours per day, seven (7) days per week

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.)
(3) Observation of individual experiencing a crisis;

XI.J.28. Each program must have the following services available as needed by the resident;

a. Evaluation
b. Observation
c. Crisis counseling
d. Alcohol and other drug disorder counseling;
e. Case Management Services
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 must be documented in the individual's record.

XI.J.29. 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 ability, 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.; and/or

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.30. The DMH only allows seclusion to be used in a CSU.

XI.J.31. 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 Mental Health Services and the DMH Review Committee prior to its use for seclusion. A room must meet the following minimum specifications in order to be considered for approval by the DMH for use in seclusion:

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

c. Be suicide resistant and have break resistant glass (if any is utilized in the room or door to the room).

XI.J.32. 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. Clearly define seclusion and the appropriate conditions and documentation associated with its use. Seclusion is defined as behavioral control technique involving locked isolation. This does not include a time-out.

b. Require that seclusion is used only in emergencies to protect the individual from injuring himself/herself or others. “Emergency” is defined as a situation where the individual’s behavior is violent or aggressive and where the behavior presents an immediate and serious danger to the safety of the individual being served, other individuals served by the program, staff, or others.

c. Require that seclusion is used only when all other less restrictive alternatives have been determined to be ineffective to protect the individual or others from harm and documented in the individual's case record.

d. Require that seclusion is used only in accordance with the order of a physician or other licensed independent practitioner, as permitted by State licensure rules/regulations governing the scope of practice of the independent practitioner and the provider. This order must be documented in the case record. The following requirements must be addressed in the policies and procedures regarding the use and implementation of seclusion and implementation (as applicable) and be documented in the individual case record:

(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
(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.

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.33. 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 of the assessment must be maintained in the individual's record.

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PART XII

PSYCHIATRIC/PHYSICIAN SERVICES

XII.PPS. Psychiatric/Physician's Services are services of a medical nature provided by medically trained staff to address medical conditions related to the individual's mental illness or emotional disturbance. Medical services include medication evaluation and monitoring, nurse assessment, and medication injection. Individuals seeking mental health services and/or being referred for mental health services must begin receiving Psychiatric/Physician's Services, within fourteen (14) days of the date of the intake assessment or intake.

XII.PPS.1. Medication Evaluation and Monitoring is the intentional face-to-face interaction between a physician or a nurse practitioner and an individual for the purpose of: assessing the need for psychotropic medication, prescribing medications, and regular periodic monitoring of the medications prescribed for therapeutic effect and medical safety.

XII.PPS.2. Nursing assessment takes place between a registered nurse and an individual for the purpose of assessing extra-pyramidal symptoms, medication history, medical history, progress on medication, current symptoms, progress or lack thereof since last contact and providing education to the individual and the family about the illness and the course of available treatment.

XII.PPS.3. Medication injection is the process of a licensed practical nurse, registered nurse, physician, or nurse practitioner injecting an individual with prescribed psychotropic medication for the purpose of restoring, maintaining or improving the individual's role performance and/or mental health status.

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PART XIII

OUTPATIENT SERVICES

SECTION A- OUTPATIENT MENTAL HEALTH SERVICES

XIII.A.1. Outpatient Mental Health Services include intake bio-psycho-social assessment, and individual, family, group, and multi-family group therapies (excluding Day Treatment and Case Management Services). These are the least intensive and most typically used interventions in the mental health field.

XIII.A.2. 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 DMH Credentialed Mental Health Therapist, IDD Therapist, or Addictions Counselor. Individuals with a Master's degree and appropriate professional license may also complete the intake bio-psycho-social assessment. Individuals seeking mental health services and/or being referred for mental health services must receive the initial (intake) assessment within fourteen (14) days of the date that services are sought and/or of the date that the referral is made.

XIII.A.3. Individual Therapy is defined as one-on-one psychotherapy that takes place between a mental health therapist and the individual receiving services.

XIII.A.4. Family Therapy shall consist of psychotherapy that takes place between a mental health therapist and an individual's family members with or without the presence of the individual. Family Therapy may also include others (DHS staff, foster family members, etc.) with whom the individual lives or has a family-like relationship.

XIII.A.5. Group Therapy shall consist of 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.

XIII.A.6. Multi-Family Group Therapy shall consist of 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.

XIII.A.7. 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 using Outpatient Mental Health Services:

a. Elderly persons;

b. Individuals with serious mental illness;

c. Individuals with a co-occurring mental illness and an alcohol or other drug disorder;

d. Individuals with a co-occurring diagnosis of mental retardation and mental illness;

e. Persons discharged from inpatient care;

f. Individuals with mental illness who are homeless;

g. Children/youth with serious emotional disturbance who are homeless;

h. Children/youth with a serious emotional disturbance;

i. Children/youth with a co-occurring diagnosis of serious emotional disturbance and an alcohol or drug disorder;

j. Children/youth with a co-occurring diagnosis of serious emotional disturbance and mental retardation;

k. Children/youth transitioning from residential care (this includes psychiatric inpatient care, psychiatric residential treatment facilities, therapeutic group homes and therapeutic foster care); and

l. Youth with serious emotional disturbance in transition from the children/youth services system to adult services.

XIII.A.8. 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.

XIII.A.9. 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 CMHC.

XIII.A.10. 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 the denial (for the current school year) by the school district superintendent must be on file at the CMHC for review by DMH personnel.

XIII.A.11. 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.

XIII.A.12. 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 the person requesting services only has to make one call to arrange an appointment.

SECTION B- OUTPATIENT SUBSTANCE ABUSE AND TREATMENT/ REHABILITATION SERVICES

General Outpatient Substance Abuse and Treatment/Rehabilitation Services

XIII.B.1. General Outpatient Substance Abuse and Rehabilitation Services treatment is appropriate for individuals in need of substance abuse services whose clinical condition or environmental circumstances do not require a more intensive

level of care. Providers of General Outpatient Substance Abuse and Rehabilitation Services treatment must provide the following services:

a. Individual therapy/counseling;

b. Group therapy/counseling; and

c. Family therapy/counseling.

Intensive Outpatient Program (IOP)

XIII.B.2. The 10-week Intensive Outpatient Program (IOP) is a community-based outpatient program which provides an alternative to traditional Residential Treatment Services 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 other drug disorders than those typically addressed in Residential Treatment Services. The IOP allows individuals to continue to fulfill their obligations to family, job, and community while obtaining intensive treatment.

XIII.B.3. Intensive Outpatient Programs must provide the following services:

a. Group 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; and

c. Involvement of family to include no less than two (2) therapeutic family group sessions during the ten (10) week period, offered to meet the needs of the individual.

PART XIV

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)

XIV.A.1. A program of Assertive Community Treatment (PACT) is an individual-centered, recovery-oriented mental health service delivery model for facilitating community living, psychological rehabilitation and recovery for persons who have the most severe and persistent mental illnesses, have severe symptoms and impairments, and have not benefited from traditional outpatient programs.

XIV.A.2. The important characteristics of Programs of Assertive Community Treatment (PACT) are:

a. PACT serves individuals who may have gone without appropriate services. Consequently, the individual group is often over represented among the homeless and in jails and prisons, and has been unfairly thought to resist or avoid involvement in treatment.

b. PACT services are delivered by a group of multidisciplinary mental health staff (as defined in Standard XIV.A.5) 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. 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.

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. 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

XIV.A.3. Each PACT team must have the organizational capacity to provide a minimum staff-to-individual ratio of at least one (1) full-time equivalent (FTE) staff person for every ten (10) individuals (this ratio does not include the psychiatrist or psychiatric nurse practitioner and the program assistant).

XIV.A.4. 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.

XIV.A.5. 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 professional (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.

<u>Admission and Discharge Criteria</u>

XIV.A.6. In order to be admitted into PACT services, individuals must meet the criteria outlined in Standards XIII.A.10 through XIII.A.12 below.

XIV.A.7. 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.)

XIV.A.8. 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).

XIV.A.9. 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.

XIV.A.10. 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

XIV.A.11. 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.

XIV.A.12. 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.

XIV.A.13. The PACT team must provide a mean (i.e., average) of at least three (3) contacts per week for all individuals.

XIV.A.14. 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

XIV.A.15. 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

XIV.A.16. 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

XIV.A.17. 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.

XIV.A.18. 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

XIV.A.19. 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

XIV.A.20. 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) PACT staff members who together have a range of clinical and rehabilitation skills and expertise. The ITT members are assigned to work with an individual receiving services by the team leader and the psychiatrist/psychiatric nurse practitioner by the time of the first Individual Service Planning meeting or thirty (30) days after admission. The core members of the ITT are the service coordinator, the psychiatrist/psychiatric nurse practitioner, and one (1) clinical or rehabilitation staff person who shares case coordination tasks and substitutes for the service coordinator when he or she is not working. The ITT has continuous responsibility to: 1) be knowledgeable about the individual's life, circumstances, goals and desires; 2) collaborate with the individual to develop and write the Individual Service Plan; 3) offer options and choices in the Individual Service Plan; 4) ensure that immediate changes are made as an individual's needs change; and 5) advocate for the individual's wishes, rights, and preferences. The ITT is responsible to provide much of the individual's treatment, rehabilitation, and support services. Individual treatment team members are assigned to take separate service roles with the individual as specified by the individual and the ITT in the Individual Service Plan.

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; and

(f) Comply with Part IV, Section J.

e. Co-Occurring Substance Abuse Services

(1) Co-Occurring Substance Abuse Services are the provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has individual-determined goals. This must include but is not limited to individual and group interventions in:

(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; and

(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; and

(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; and

3. Services to help individuals restore relationships with children who are not in the individual's custody.

Stakeholder Advisory Groups

XIV.A.21. 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.

XIV.A.22. 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; and

f. Promote and ensure individuals' empowerment and recovery values in assertive community treatment programs.

<u>Program Requirements</u>

XIV.A.23. 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

XIV.B.1. Co-Occurring Disorders Services are provided to individuals who are affected by both a diagnosed mental illness and substance abuse disorder.

XIV.B.2. Providers must utilize a screening tool and assessment provided by the DMH.

SECTION C- DROP IN CENTER SERVICES

XIV.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.

XIV.C.2. 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; and

c. Chronically homeless.

XIV.C.3. 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.

XIV.C.4. 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.

XIV.C.5. The program must have an annual average daily attendance of eight (8) individuals.

XIV.C.6. All program space must be accessible to both individuals and staff. There are to be no "staff-only" or "individual/member-only" spaces.

XIV.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 by DMH.

XIV.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 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.

XIV.C.9. The structured activities of the program must be designed to:

a. Maintain individuals in an environment less restrictive than inpatient or therapeutic Residential Treatment Services

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

g. Promote empowerment and recovery.

XIV.C.10. 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.

XIV.C.11. 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.

XIV.C.12. Staffing ratio must be at least one (1) staff member at all times for every twelve (12) individuals served by the program.

XIV.C.13. 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.

XIV.C.14. Drop In Center programs must have a board or advisory council that it made up of fifty percent (50%) consumers of mental health services.

XIV.C.15. 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

XIV.D.1. All programs certified as DMH/C must provide access to inpatient services in the individual's locale when appropriate.

XIV.D.2. The provider must have written policies and procedures for referral to inpatient services in the community, should an individual require such services.

XIV.D.3. 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 Center'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, Civil Commitment Examination Services, and Aftercare Services.

SECTION E- PRE-EVALUATION SCREENING AND CIVIL COMMITMENT EXAMINATION SERVICES

XIV.E.1. Pre-Evaluation Screening and a Civil Commitment Examination are two separate 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.

XIV.E.2. 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.

XIV.E.3. The Pre-Evaluation Screening must be conducted by qualified staff of a regional CMHC, and

a. Be performed by:

(1) A certified licensed psychologist or physician; or

(2) A person 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 (6) months of experience working with individuals with serious mental illness or serious emotional disturbance and;
   (b) At least two (2) behavioral observations of Pre-Evaluation Screenings performed by qualified staff.

b. Be performed in accordance with current Mississippi civil commitment statutes.

c. Be documented on the forms and provide the information required by the civil commitment law and/or the DMH.

XIV.E.4. If the Civil Commitment Examination is conducted, 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 (as required in MCA Section 41-21-67 (2)).

b. Be documented on required forms, and provide information required by law or the DMH. Documentation must include information in the individual record of the Commitment Examination results and the official disposition following the examination

c. Include the evaluation of the individual's social and environmental support systems

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

XIV.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 annual on-site visits to each Holding Facility to ensure they are in compliance with the standards below.

Policies & Procedures

XIV.F.2. 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.

XIV.F.3. 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.

e. Have a copy of the Memorandum of Understanding (MOU) or contract between the Holding Facility and the Community Mental Health Center to describe how mental health services will be provided while people are housed in the Holding Facility.

Personnel Policies

XIV.F.4. 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; and
   (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

XIV.F.5. 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.

XIV.F.6. Documentation of training of individual staff must be included in individual training/personnel records and must include:

a. Date of training
b. Topic(s) addressed;
b. Name(s) of presenter(s) and qualifications;
c. Contact hours (actual time spent in training).

XIV.F.7. 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

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 medical response; and

k. Suicide precautions.

Procedures for Admitting and Housing Individuals

XIV.F.8. Each facility shall have written procedures for admission of individuals who have been involuntarily civilly committed and awaiting transportation. These procedures shall include, but not be limited to, the following:

a. Make a complete search of the individual and his/her possessions;
b. Properly inventory and store individual's personal property;
c. Require any necessary personal hygiene activities (e.g., shower or hair care, if needed);
d. Issue clean, laundered clothing or appropriate garments (e.g., suicide risk reduction garments);
e. Issue allowable personal hygiene articles;
f. Perform health/medical screening;
g. Record basic personal data and information to be used for mail and visiting lists; and
h. Provide a verbal orientation of the individual to the facility and daily routines.

Environment/Safety

XIV.F.9. 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.

XIV.F.10. Rooms used for housing individuals must be free from structures and/or fixtures that could be used by detainees to harm themselves.

XIV.F.11. 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

XIV.F.12. The following must be conducted immediately upon arrival:

a. Suicide assessment (using a DMH approved screening instrument); and
b. Violence risk assessment (using a DMH approved screening instrument)

XIV.F.13. 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.

XIV.F.14. If the risk level for suicide is deemed "high," immediate suicide prevention actions must be instituted.

Assessment and Clinical Management

XIV.F.15. Each Holding Facility must 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;
(1) Medical/drug history;
(2) Allergy history; and
(3) Psychiatric history (note: look at pre-evaluation form).

XIV.F.16. Clinical Management of the individual being held must 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. Ongoing assessment and 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; and

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

XIV.F.17. 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 800-772-4057
   (2) Dept. of Mental Health 877-210-8513
b. Chaplain services
c. Telephone contact
d. Visits with family members

SECTION G- CONSULTATION AND EDUCATION SERVICES

XIV.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.

XIV.G.2. The provider of the Consultation and Education Services must develop and implement a written plan to provide these services. The plan must include a range of activities for:

a. Developing and coordinating effective mental health education, consultation, and public information programs; and

b. Increasing the community awareness of mental health related issues.

XIV.G.3. The Consultation and Education Services 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 co-occurring diagnosis (MH/A&D/MR);

f. Individuals with a mental illness who are homeless;

g. Military families and the military community; and

h. Other populations defined by the provider.

XIV.G.4. The program must develop linkages with other health and social agencies that serve the target populations.

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PART XV

ALZHEIMER’S AND OTHER DEMENTIA SERVICES

XV.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.

XV.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 and on 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.

XV.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

XV.A.3. 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).

XV.A.4. 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 at least one (1) year of supervisory experience in a mental health, social or health service setting or two (2) years of comparable technical and human services training, with demonstrated competence and experience as a manager in a human services setting

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 a high school diploma or equivalent and at least one (1) year of experience in working with adults in a health care or social service setting;

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; and

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.

XV.A.5. The ratio of staff to individuals served by the program must be at least one (1) full-time staff member per four (4) individuals served. The program supervisor may be included in the staffing ratio if he/she is on-site and actively engaged in the program.

Therapeutic Activities

XV.A.6. 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.

XV.A.7. 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.

XV.A.8. Individuals must be allowed time for rest and relaxation and to attend to personal and health care needs.

XV.A.9. 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.

XV.A.10. 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

XV.A.11. Family education and training must be made available at least monthly to family(ies) and/or caregiver(s) of individuals served by the program. This training must be designed to improve the well-being and functional level of the individuals served and/or families/caregivers. Provision of family education and training must be documented in the case record. A family education log must be kept by the Program Supervisor

XV.A.12. Opportunities for case staffing (including problem-solving as to how to respond to challenging scenarios involving individuals who receive services) between supervisory and all program staff must be made on a monthly basis or more frequently if determined necessary by the program supervisor.

Assistance with Activities of Daily Living

XV.A.13. 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

XV.A.14. 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.

XV.A.15. 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

XV.A.16. 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.

XV.A.17. The adult day service center facility must provide at least fifty (50) 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.

XV.A.18. 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.

XV.A.19. The facility must have an identified separate space available for individuals and/or family/caregivers to have private discussions with staff.

XV.A.20. The facility's restrooms must be located as near the activity area(s) as possible

XV.A.21. 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.

XV.A.22. 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.

XV.A.23. Outside space that is used for outdoor activities must be safe, accessible to indoor areas, and accessible to individuals with disability(ies).

XV.A.24. The program must have secure, exterior pathway(s), a minimum of four (4) feet in width.

XV.A.25. Adequate outside seating must be provided.

XV.A.26. 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.

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PART XVI

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

XVI.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 should be designed to target a specific group of children/youth and/or their families, such as children/youth who have been abused or neglected, teenage parents and their children, and young children and their parents. Children/youth identified as having a serious emotional disturbance and/or their families may also be targeted to receive specialized intervention early in the course of identification of the emotional disturbance.

XVI.A.2. A staff member must be designated to plan, coordinate and evaluate Prevention/Early Intervention Services.

XVI.A.3. 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/youth; or
(2) Effective education activities, such as parent education, designed to assist individuals in developing or improving critical life skills and to enhance social competency thereby changing the conditions that reinforce inappropriate behavior; or
(3) Consultation/education activities that are designed to include, but not be limited to, education and awareness activities to assist in the maintenance and/or improvement of services; or,
(4) Early Intervention services, including screening, assessment, referral, counseling, and/or crisis intervention services, designed to serve individuals identified as "high risk" and who are exhibiting signs of dysfunctional behaviors.

b. Development of linkages with other health and social service agencies, particularly with those serving children.

XVI.A.4. Prevention/Early Intervention Programs must maintain records documenting utilization of strategies as described in Standard XV.A.3.

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

XVI.B.1. Family Support and Education Services, which provide self-help and mutual support for families of youth with mental illness or mental health challenges are based on the view that a person who is parenting or has parented a child experiencing emotional or behavioral health disorders can articulate the understanding of their experiences with another parent or family member.

XVI.B.2. 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.

XVI.B.3. 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; and

d. Description of service components of Family Support and Education Services.

XVI.B.4. A variety of family education activities appropriate for families of children/youth with behavioral/conduct or emotional disorders must be made available through pamphlets, brochures, workshops, social activities, or other appropriate meetings or methods/types of presentations with an individual family or groups of families. These activities must be documented and 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 fourteen (14) and up.

SECTION C- MAKING A PLAN (MAP) TEAMS

XVI.C.1. Making a Plan (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.

XVI.C.2. All providers certified as Community Mental Health Centers (DMH-C) must make available or participate in at least two (2) standing MAP Teams in each CMHC region.

XVI.C.3. All providers certified as DMH/C must have a written plan that describes how each county in their catchment area will develop or have access to a MAP Team. The plan must include time lines for ensuring each county has access to or has developed a MAP Team. Additionally, the plan must be available for DMH Review.

XVI.C.4. Before referring a child/youth to a PRTF, the CMHC must first have the local MAP Team review the situation to ensure all available resources and service options have been utilized. This does not include those children/youth who are in immediate need of acute hospitalization due to suicidal or homicidal ideations.

XVI.C.5. Each MAP Team must be comprised of at least one child behavioral health representative employed by the CMHC who has a Bachelor's degree. In addition, there must be at least one representative from each of the following:

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

d. County or Regional Office of the State Department of Rehabilitation Services

e. County or Regional Office of the Mississippi State Department of Health

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.

XVI.C.6. The Community Mental Health Center (DMH-C) must maintain a current written interagency agreement with agencies participating in the MAP Team.

XVI.C.7. A CMHC Master's level therapist must participate in the Regional A-Team Meetings that are held by the Mississippi Department of Human Services (MDHS) in their catchment areas. *(Please refer to the DMH Division of Children and Youth Services Directory for definition and locations of* MDHS Regional A-Teams.)

SECTION D- FETAL ALCOHOL SPECTRUM DISORDERS (FASD) SCREENING, DIAGNOSIS AND TREATMENT SERVICES

XVI.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. 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.

XVI.D.2. Children ages birth to age eighteen (18) must be screened within six (6) months of Intake to determine if there is a need for a Fetal Alcohol Spectrum Disorders (FASD) diagnostic evaluation. Youth ages eighteen (18) to twenty-four (24) may be screened for an FASD if there is indication of prenatal alcohol exposure.

XVI.D.3. 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.

XVI.D.4. 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.

XVI.D.5. 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.

XVI.D.6. If a child's initial FASD screening result is negative, the screening process must be repeated at the first (initial) 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.

XVI.D.7. 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.

XVI.D.8. Treatments and interventions recommended by the FASD multi-disciplinary diagnostic team must be either provided or facilitated by the CMHC. Referral to the local MAP Team should be made when appropriate.

XVI.D.9. 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.

XVI.D.10. 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

XVI.E.1. Respite is a short-term planned relief care in the home or community for children/youth with serious emotional/behavioral disturbances or mental health challenges. This service offers time out for caregivers and children/youth, helping family members to cope with their responsibilities, to rest and regroup, facilitates stability, and feel less isolated from the community, family and friends. The provision of services is child-centered with the family participating in all decision-making, community based and culturally competent.

XVI.E.2. 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.

XVI.E.3. 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; and

c. Description of procedures for developing and implementing behavior change/management programs for children/youth served on a regular basis.

XVI.E.4. Providers of Respite Services must maintain documentation of linkages with other health and social service agencies, particularly those that serve children/youth.

XVI.E.5. 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.

XVI.E.6. 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.

d. Signed confidentiality statement

e. Service Agreement between the caregiver, the provider, and the agency (MSFAA) clearly stating what entity agrees to do while services are being provided.

XVI.E.7. 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 XVII

PEER SUPPORT SERVICES

XVII.PS.1. Peer Support Services are person-centered activities that allow consumers mental health services and their 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.

XVII.PS.2. 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 provided 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.

XVII.PS.3. 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.

XVII.PS.4. 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.

XVII.PS.5. 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.

XVII.PS.6. 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.

XVII.PS.7. Peer Support Services must be supervised by a mental health professional who has completed the DMH required peer supervisory training.

XVII.PS.8. 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.

XVII.PS.9. 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 XVIII

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

XVIII.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.

XVIII.A.2. 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 about the First Steps Early Intervention Program (FSEIP) unless they are 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; and
(3) Participate in IFSP meetings to discuss transition activities as requested through written prior notice from First Steps.

XVIII.A.3. DMH Staff or Staff of the DMH Certified Provider involved with First Steps Early Intervention Programs (FSEIP) activities 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 ninety (90) 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 within 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.

XVIII.A.4. Child Development Services must adhere to the following:

a. Within thirty (30) days of admission and at least annually thereafter, conduct an educational assessment to determine a child's skills in the areas of cognition, communication, fine and gross motor, adaptive, and socialization for utilization in the development of an individualized service plan.

b. Provide or access services as indicated in a child's evaluation reports from a licensed speech-language pathologist (SLP), qualified teacher, registered occupational therapist (OT), registered physical therapist (PT), and/or other qualified personnel.

c. Document the following in the child's record regarding OT/PT/speech services:

(1) Training provided by the OT/PT/speech therapists(s) for program staff
(2) Any special techniques needed for the safe handling of a child
(3) How program staff might implement any recommended special procedures/techniques into the child's educational program.

d. 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

XVIII.B.1. ID/DD Waiver Day Services - 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.

XVIII.B.2. Day Services-Adults 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-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.

XVIII.B.3. Day Services - 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. There must be a minimum of fifty (50) square feet of usable space per every person in the program. Additional square footage may be required 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
(2) Activities which address leisure/social/other community events.

e. All community integration activities must be based on choices/requests of the individuals served. Documentation of the choices offered and the chosen activities must be maintained in each person's record on the designated form.

f. Individuals who may require one-on-one assistance must be offered the opportunity to participate in all activities.

XVIII.B.4. 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.

XVIII.B.5. When providing opportunities for community inclusion, there must be at least one (1) staff person for every six (6) people, if none of the six (6) requires mobility assistance. If anyone in a group of six (6) requires mobility assistance, there must be at least two (2) staff (the driver and one other) for the group of six (6) people. Depending on individual requirements for support, additional staff may be required.

XVIII.B.6. A person cannot be excluded from participating in community activities because he/she requires one-on-one assistance.

XVIII.B.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.

XVIII.B.8. 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.

XVIII.B.9. 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- PREVOCATIONAL SERVICES

XVIII.C.1. Prevocational Services are provided to persons not expected to be able to join the general workforce within one year (excluding Supported Employment Services). Activities can be either center based or community based and 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.

XVIII.C.2. If anyone receiving Prevocational Services receives sub-minimum wage for any type of contract or piece-rate work, the program must be housed in a certified Work Activity Center that meets all the requirements of the U.S. Department of Labor.

XVIII.C.3. The provider must administer a functional skills assessment using instruments specified by BIDD.

XVIII.C.4. 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.

XVIII.C.5. 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. Encouragement and support of good work habits

d. Teaching/demonstration of the proper care and handling of equipment, materials, tools, and machines

e. Teaching/encouragement of appropriate responses to requests from

supervisors and/or co-workers

f. 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

g. Personal care/assistance, but it may not comprise the entirety of the service

h. 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 one (1) staff person for every six (6) people, if none of the six (6) requires mobility assistance. If anyone in a group of six (6) requires mobility assistance, there must be at least two (2) staff (the driver and one other) for the group of six (6) people. Depending on individual requirements for support, additional staff may be required.
(3) Include individuals who may require one-on-one assistance.

XVIII.C.6. 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.

XVIII.C.7. 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.

XVIII.C.8. 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)).

XVIII.C.9. The program must be in operation a minimum of five (5) days a week, at least six (6) hours per day.

XVIII.C.10. The program must ensure it will make available lunch and/or snacks for individuals who do not bring their own.

SECTION D- WORK ACTIVITY SERVICES

XVIII.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.)

XVIII.D.2. 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.

XVIII.D.3. 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.

XVIII.D.4. The program must have adequate work to keep individuals productively occupied while at the 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 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.

(3) Programs which do not have sufficient documentation of how they have tried to locate and obtain adequate work may be decertified.

XVIII.D.5. 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.

d. Allowing flex time, part-time, or extended break time.

XVIII.D.6. 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

e. Method of payment (cash, check, direct deposit.).

XVIII.D.7. 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

e. The individual's signature indicating he/she received a written statement. These signatures must be maintained in the individual's record.

XVIII.D.8. Pay periods cannot exceed thirty-one (31) calendar days.

XVIII.D.9. 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.

XVIII.D.10. 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.

XVIII.D.11. 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.

XVIII.D.12. Work Activity center staff_must meet at least annually with the individuals to discuss matters of mutual concern. The program must maintain minutes for the meeting and ensure at least the following are addressed:

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.

XVIII.D.13. 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.

XVIII.D.14. 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

XVIII.E.1. Supported Employment Services increase independence, community integration, and productivity of individuals with IDD 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 Services may consist of activities to support and/or assist an individual in starting his/her own business.

XVIII.E.2. Supported Employment Services consists of three types of individualized activities designed to assist/support an individual in obtaining and maintaining a job in the community. Providers must be able to provide all three of the activities for Supported Employment Services.

a. Job development and placement
b. Training/coaching to assist/support the individual in learning the job requirements and how to perform it
c. Varying levels/types of ongoing job support necessary for the individual to maintain the job.

XVIII.E.3. 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 Centers.

f. Cannot be used to support volunteer work or unpaid internships.

g. Include personal care/assistance when specified in the individual's Supported Employment Service Plan.

SECTION F- ID/DD WAIVER SUPPORT COORDINATION SERVICES

XVIII.F.1. Support Coordination Services are provided to individuals enrolled in the ID/DD Waiver. Support Coordination services coordinate and monitor all services an individual on the ID/DD Waiver receives, regardless of funding source, to ensure services are adequate, appropriate, meet individual needs, and ensure the individual's health and welfare needs are met.

XVIII.F.2. 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
(5) Requests for readmission.

e. Notifying each individual of:

(1) Reduction in service(s)
(2) Termination of service(s)
(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
(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

l. Making phone contacts at the frequency required by BIDD.

XVIII.F.3. 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.

XVIII.F.4. The maximum case load for a support coordinator is thirty-five (35) waiver participants.

XVIII.F.5. 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.

XVIII.F.6. Support coordinators are responsible for maintaining electronic files as required by the BIDD.

VVIII.F.7. Support Coordinators must adhere to the requirements in the ID/DD Waiver Support Coordination Manual.

SECTION G- COMMUNITY RESPITE SERVICES

XVIII.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 Services ~~is~~ are provided at times when other types of services are not available such as evenings and weekends.

XVIII.G.2. Community Respite Services must be provided in a DMH certified site in the community.

XVIII.G.3. Community Respite Services cannot be provided over night.

XVIII.G.4. Individuals attending a Community Respite Services cannot be left unattended at any time.

XVIII.G.5. Individuals must be engaged in age appropriate chosen activities during the provision of Community Respite Services.

XVIII.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.

XVIII.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

XVIII.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.

XVIII.H.2. In-Home Respite Services consist~~s~~ 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.

XVIII.H.3. In-Home Respite Services are 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.

XVIII.H.4. 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.

XVIII.H.5. Individuals cannot be left unattended at any time during the provision of In-Home Respite Services

XVIII.H.6. Nurses who provide In-Home Respite Services must practice according the Mississippi Nurse Practice Act and Nursing Rules and Regulations.

SECTION I- BEHAVIOR SUPPORT AND INTERVENTION SERVICES

XVIII.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 others.

XVIII.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.

XVIII.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. Behavior support/interventionists may provide services at the same time another service is being provided as long as it is clearly documented that the intervention is:

   (1) Observing the individual for the Functional Behavior Assessment.
   (2) Collecting data via observation and intervention.
   (3) Training staff who provide another ID/DD Waiver service to the individual.
   (4) Shadowing and/or intervening are undesired behaviors while the individual is receiving another ID/DD Waiver service.

e. Assisting the individual in becoming more effective in controlling his/her own behavior either through counseling or by implementing the behavioral support plan.

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.

XVIII.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
   (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)
   (3) The behavior support/interventionist.

XVIII.I.4. Behavior Support/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/Intervention Services 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/interventionist must document in the record the methods by which all parties are collaborating to ensure consistency of methods and agreement about outcomes.

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PART XIX

SUBSTANCE ABUSE PREVENTION AND TREATMENT/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, reduce, or delay substance use or abuse.

Primary substance abuse treatment consists of the following: Primary Residential Treatment, General Outpatient Services, Intensive Outpatient (IOP) Services, 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 other drug treatment and prevention programs that receive funds from and/or are certified by the DMH, Bureau of Alcohol and Drug Abuse (BADA), must comply with the Standards in Parts I through X (Section D) and applicable parts of XI and XIII.

SECTION A- GENERAL STANDARDS

XIX.A.1. All DMH funded service providers of an alcohol and other drug disorders services must submit the Mississippi Substance Abuse Management Information System (MSAMIS) report to the DMH, Bureau of Alcohol and Drug Abuse by the tenth (10th) working day of the month following the reporting period.

XIX.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.

XIX.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 HIV testing on site or offered transportation to an appropriate health care facility for testing.

XIX.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. Any individual determined to be at high risk cannot be admitted into a treatment program until testing confirms the individual does not have TB.

XIX.A.5. All providers must provide and document that all individuals receiving 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; and
(3) Current treatments and how to access them.

b. Tuberculosis (TB)

(1) Modes of transmission; and
(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; and
(4) Current treatment resources and how to access them.

XIX.A.6. Transitional Residential and Aftercare Programs must also provide the services outlined in Standard XIX.A.5, unless the program can provide documentation that the individual received the educational information prior to a transfer to a less restrictive level of care.

XIX.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 placement in a Residential Treatment Program is not available, 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 an appropriate Residential Treatment Program is identified. This process must be completed within forty-eight (48) hours of the initiation of the Initial Assessment and be documented by the initial service provider. Written documentation must be submitted to the DMH Bureau of Alcohol and Drug Abuse.

XIX.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 and Part XVIII. The DMH will determine if the documentation is sufficient to support certification in the specific substance abuse services areas.

XIX.A.9. Intensive Outpatient Programs must be limited to twelve (12) individuals per session.

XIX.A.10. Caseloads for primary residential program staff must be no more than twelve (12) adults or eight (8) adolescents.

XIX.A.11. 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. Programs must disclose if they are certified by the DMH to conduct DUI assessments.

XIX.A.12. All programs must have a physical environment which provides designated space for privacy of individual and group counseling sessions.

SECTION B- DETOXIFICATION SERVICES

XIX.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.

XIX.B.2. 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; and

c. A description of the method by which referrals are made to physicians and/or hospitals for appropriate medical intervention.

XIX.B.3. Providers of Detoxification Services must maintain documentation of hourly observation of the individual receiving services during the first twenty-four (24) hours of the detoxification program and every two (2) hours during the following twenty-four (24) hours, and as needed thereafter, when medical or social detoxification is prescribed by a physician.

XIX.B.4. 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.

XIX.B.5. 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- OUTREACH/AFTERCARE SERVICES

XIX.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 Services also offers the individual with structured support and assistance which may include securing additional needed services from (CMHCs) or from other health/human service providers and maintaining contact and involvement with the individual's family.

XIX.C.2. 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 an Outreach/Aftercare worker, as needed

d. Employer contacts, as needed

e. Referrals and linkage with additional needed services.

XIX.C.3. Outreach/Aftercare Services staff must make at least one (1) attempt to contact each member per month. Group or individual sessions are acceptable as contacts.

XIX.C.4. The Outreach/Aftercare Services 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).

XIX.C.5. The Outreach/Aftercare Services 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.

XIX.C.6. 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

XIX.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.

XIX.D.2. 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.

XIX.D.3. All DMH funded 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.

XIX.D.4. All prevention providers must have a staff member designated to coordinate the prevention program.

XIX.D.5. 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.

XIX.D.6. No Prevention Services will be provided to persons who are actively engaged in any alcohol or other drug abuse treatment program.

XIX.D.7. Individuals working in Prevention Services must have their own working computer (provided by the certified provider) with Internet access.

SECTION E- DUI DIAGNOSTIC ASSESSMENT SERVICES FOR SECOND AND SUBSEQUENT OFFENDERS

XIX.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.

XIX.E.2. 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.

XIX.E.3. The program must have written policies and procedures and adhere to those policies and procedures which describe:

a. The manner in which treatment components of the DUI Assessment Process are provided

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.

XIX.E.4. 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 to administer the diagnostic tool, at least one staff member must be certified.

c. An Initial Assessment.

XIX.E.5. Individuals receiving DUI assessment/treatment services through a DUI Outpatient Program Track must receive a minimum of twenty (20) hours of direct service (individual and/or group therapy), in no less than ten (10) separate therapeutic sessions or as otherwise specified by the DMH BADA, before receiving the DMH Certification of DUI In-Depth Diagnostic Assessment and Treatment Form. Documentation of treatment will be maintained in the individual's record.

XIX.E.6. 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 BADA within ten (10) working days of when an individual has successfully completed the treatment program.

XIX.E.7. 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.

GLOSSARY

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Glossary

Certified Peer Support Specialist (CPS) - CPS provide non-clinical peer support that is person-centered and recovery/resiliency focused. CPS is a self-identified consumer/family member (past or present) of mental health services who has successfully completed the Department of Mental Health approved Certified Peer Specialist training and certification exam.

Chemical restraint - a medication used to control behavior or to restrict the individual's freedom of movement and is not standard treatment of the individual's medical or psychiatric condition.

Community-based - services and supports are located in or strongly linked to the community, in the least restrictive setting supportive of an individual's safety and treatment needs. Services and supports should be delivered responsibly and seamlessly where the person lives, works, learns and interacts.

Complaint - verbal statement made by an individual receiving services alleging a violation of rights or policy.

Cultural Competency - the acceptance and respect for difference, continuing self-assessment regarding culture, attention to dynamics of difference, ongoing development of cultural knowledge and resources and flexibility within service models to work towards better meeting the needs of minority populations.

Days - calendar days.

Director – an individual with overall responsibility for a service or service area. This individual must have at least a Master's degree in a mental health or related field and (1) a professional license or (2) DMH Credentials as a Mental Health Therapist or DMH credentialed Intellectual/Developmental Disabilities Therapist (as appropriate to the population being served and/or supervised).

DMH Credentials – examples include Certified Mental Health Therapist (CMHT), Certified Intellectual or Developmental Disabilities Therapist (CIDDT).

Grievance - a written statement made by an individual receiving services alleging a violation of rights or policy.

Immediate family members - spouse, parent, stepparent, sibling, child, or stepchild.

Mechanical restraint - the use of a mechanical device, material, or equipment attached or adjacent to the individual's body that he or she cannot easily remove that restricts freedom of movement or normal access to one's body.

Medical Screening - Components of medical screening include: patient personal information, doctor's information (name, etc.), exam information – BP, pulse, height, weight, current diagnosis, current meds, statement of freedom from communicable disease, physical and dietary limitations and allergies. Must be signed by a licensed physician/nurse practitioner.

Peer- A self-identified consumer or family member of a child consumer of mental health services

Peer Support Service- Peer Support Services are person-centered activities that allow consumers/family members the opportunity to direct their own recovery and advocacy processes. Peer Support is a helping relationship between peers and/or family member that is directed toward the achievement of specific goals defined by the individual. Peer Support Services include a wide range of structured activities to assist individuals in their individualized recovery/resiliency process. Specific goals may include the areas of wellness and recovery/resiliency, education and employment, crisis support, housing, social networking, development of community roles and natural supports, self-determination and individual advocacy.

Peer Support Supervisor - An individual credentialed according to the standards and guidelines determined by DMH. Prior to, or immediately upon acceptance in a Peer Support Supervisory position, this individual will be required to receive basic Peer Specialist training specifically developed for supervision within the Peer Specialist program, as provided by DMH.

Person-centered process – identification of the supports needed for individual recovery and resilience. Individualized and Person-centered means that the combination of services and supports should respond to an individual's needs, and should work with the strengths unique to each individual's natural and community supports. Services and supports should be designed to help the person served identify and achieve his/her own recovery goals. The public mental health system must also recognize, respect and accommodate differences as they relate to culture/ethnicity/race, religion, gender identity and sexual orientation. However, an individualize/person-centered process must recognize the importance of the family and fact that supports and services impact the entire family.

Physical escort - the temporary holding of the hand, wrist, arm, shoulder, or back for the purpose of inducing an individual who is acting out to walk to a safe location.

Physical restraint - personal restriction that immobilizes or reduces the ability of an individual to move his or her arms, legs, or head freely. Such term does not include a physical escort.

Professional License – examples include Licensed Professional Counselor (LPC), Licensed Psychologist, Licensed Master Social Worker (LMSW), Licensed Certified Social Worker (LCSW), Medical Doctor.

Program - the single service provision site.

Provider - the overall agency/entity. Provider does not refer to an individual staff member or program site.

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

Results-oriented - services and supports should lead to improved outcomes for the person served. We want each person to have as much responsibility and self -sufficiency as they can, taking into consideration their age, goals and personal circumstances. Recovery- oriented services means services that are dedicated to and organized around actively helping each individual served to achieve full personal recovery in their real life and service environment.

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

Supervisor - an individual with predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services for such areas as Work Activity Services, Day Services-Adults, Psychosocial Rehabilitation/Clubhouse Services, Day Support Services etc. This individual must have at least a Bachelor's degree in a Mental Health, Intellectual/Developmental Disabilities, or a related field, and be under the supervision of an individual with a Master's degree in a Mental Health, Intellectual/Developmental Disabilities, or a related field.

Source: Miss Code Ann. 41-4-7 (f)