Section: General Services
Policy: Initial Assessment/Eligibility
Policy No.: GS 01
Effective: 01/01/1997
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services that all individuals for whom mental health services appear to be appropriate shall have an initial screening and/or assessment completed in compliance with DMH Operational Standards and the DMH Record Guide. The initial assessment will be initiated on the first day of service (emergency contact excluded).

PURPOSE: To determine if mental health services are necessary, and, if so, the type(s), array, and intensity of delivery of services needed.

PROCEDURE: All individuals for whom a referral to mental health services is made shall have a mental health Initial Assessment completed within 30 days of admission and/or readmission. The following priority groups of individuals with serious mental illness, children/youth with serious emotional disturbance and individuals with an intellectual/ developmental disability must receive an Initial Assessment within fourteen (14) days of the date that services are sought and/or the date the referral is made:

- Individuals discharged from an inpatient psychiatric facility
- Individuals discharged from an institution
- Individuals discharged or transferred from Crisis Stabilization Services
- Individuals referred from Crisis Response

The initial assessment shall be conducted in any Community Counseling Services offices by a master's level therapist who meets the qualification as outlined in the current DMH Operational Standards and will include the signature and credentials of the staff member conducting the assessment. Intakes are conducted in the office so necessary financial/payment information can be secured and verified and so Office Managers/Medical Records Technicians can complete the administrative intake portions which includes all demographic, financial, and applicable insurance information. In addition, intakes are completed in the office so necessary payment can be collected and necessary receipts can be given for any payment received. For those individuals seeking services whose third-party payor/insurance and or a grant (i.e., crisis) will fully cover the cost of the intake, an exception can be made to conduct the intake in a location other than a CCS office when it is not feasible and/or difficult for the individual to come to the office for the intake. In these situations, the clinical staff is responsible for completing the administrative intake portion. For children/youth, the intake interview shall be conducted with the parent(s)/legal guardian(s) so that accurate information may be obtained. If someone other than the parent is the legal guardian, appropriate documentation must be obtained and included in the child's/youth file.

For all individuals receiving mental health services and/or substance use disorders services, the initial biopsychosocial assessment and subsequent biopsychosocial assessments are face-to-face contacts with the purpose of 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. As a result of the initial assessment and other assessment instruments utilized, information is documented on the initial assessment and the individual service plan to support a determination of serious mental illness (SMI) for adults and severed emotional disturbance (SED) for children/youth.

Timelines for completion:

- All Outpatient and Support Services will initiate the completion of the initial assessment on the first day of service to be completed within thirty (30) days from the date of admission
- All Community Living Services will initiate the completion of the initial biopsychosocial assessment on the first day of service to be completed within seven (7) days from the date of admission
- All SUD Residential Services will initiate the completion of the initial biopsychosocial assessment on the first day of service to be completed within five (5) days from the date of admission
- The initial assessment will be completed within twenty-four (24) hours of admission for any crisis or emergency services

SMI/SED/IDD Determination:

As outlined in the current DMH Operational Standards, the following information/criteria must be met to support a determination of SMI:

- An individual who meets the criteria for one of the eligible diagnostic categories defined in the most current version of the DSM
- Adults age eighteen (18) or over
- 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

As outlined in the current DMH Operational Standards, the following information/criteria must be met to support a determination of SED:

- Child/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)
- Youth age birth up to twenty-one (21) years
- 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

For individuals with IDD who have been evaluated by one (1) of the five (5) Diagnostic and Evaluation Teams, by a school district or by another approved examiner to determine the need for/eligibility for ICF/IDD level of care, special education, and or a Certificate of Developmental Disability, the evaluation(s) are maintained in each individual's record as part of the Initial Assessment process. See Policy IDD 01 regarding all information that must be documented to support admission to IDD programs.
Upon completion of the initial assessment and other assessment instruments/functional assessments, the therapist completing the intake will record initial behavioral observations, identify functional limitations, make an initial diagnostic impression, and make recommendations regarding needed services.

Functional Assessments:
For **adults** receiving mental health services, the following DMH approved functional assessment will be completed within thirty (30) days after Initial Assessment and at least every six months (6) thereafter:

- DLA-20

Other assessments may be utilized, but are not limited to, the following:

- Achenbach System of Empirically Based Assessment (ASEBA), specifically the Adult/Older Adult Behavior Checklist for those individuals recommended for PSR/Senior PSR
- Other instruments as deemed appropriate based on presenting issues/diagnosis (i.e., WHODAS 2.0, Adult Wellness assessment, Beck Depression/Anxiety Inventory)

For **children/youth** receiving mental health services, the following DMH approved functional assessment will be completed within thirty (30) days after Initial Assessment and at least every six months (6) thereafter:

- Child and Adolescent Functional Assessment (CAFAS)

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

Other assessments may be utilized, but are not limited to, the following:

- Achenbach System of Empirically Based Assessment (ASEBA), specifically the Child Behavior Checklist
- The Devereux Scale of Mental Disorders for children/youth recommended for day treatment
- Other instruments as deemed appropriate based on presenting issues/diagnosis (i.e., WHODAS 2.0, Conner Rating Scale, Beck Depression/Anxiety Inventory for youth)

For **adults receiving substance use disorders service**, the following DMH approved functional assessment will be completed within thirty (30) days after Initial Assessment and at least every six months (6) thereafter:

- DLA-20 A/D

Other assessments may be utilized, but are not limited to, the following:

- SASSI
- CAGE
- Other instruments as deemed appropriate based on presenting issues/diagnosis

TB/HIV/STD Risk Assessment & Educational Activities: All individuals receiving substance abuse treatment services must receive the Risk Assessment Interview and Educational Activities for TB/HIV/STD at the time of the Intake/Initial Assessment, and within timelines as outlined in the DMH Record Guide, except under the following circumstances:

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

DUI Assessment: In addition to the Initial Assessment, the following must be completed 1) A DUI Diagnostic Assessment for individuals in the DUI program for second and subsequent offenders must contain a motor vehicle report (or evidence of a written request) which is obtained by the service provider from the Department of Public Safety after appropriate release forms have been obtained. This record must contain Previous DUI's and Moving Violations. 2) Results and interpretation of the SASSI or other DMH Bureau of Alcohol and Drug Abuse approved tool. In order to administer the diagnostic tool, at least one (1) staff member must be certified.

<u>Psychiatric/Physician Services:</u>

For individuals in need of Psychiatric/Physician Services, an appointment for those services must be made and documented during the original biopsychosocial assessment. Adults with a serious mental illness (SMI) and children and youth with serious emotional disturbance (SED) must be seen in person or by telemedicine and evaluated by a licensed physician, licensed psychologist, psychiatric/mental health nurse practitioner, physician assistant, licensed professional counselor (LPC) , licensed marriage and family therapist (LMFT), or Licensed Certified (clinical) Social Worker (LCSW) to certify that the services planned are medically/therapeutically necessary for the treatment of the individual. These professionals must see the individual in person or by telemedicine annually (or more often if medically indicated) to certify the same in the record. Certification and recertification must be documented as part of the individual service plan directing treatment/support.

General Information: During the initial assessment, the therapist reviews/explains to the individual seeking services and/or his/her parent(s)/legal guardian(s) the Consent to Receive Services/Acknowledgement of Grievance/Rights of Individuals Receiving Services and has the individual and/or parent(s)/legal guardian(s) sign, and gives a copy to the individual and/or parent(s)/legal guardian(s). Rights of individuals receiving services and his/her responsibilities while receiving services are reviewed. During the clinical intake, the therapist not only talks with the individual and/or parent(s)/legal guardian(s) about the individual's rights, he/she also explains the responsibilities of the individual receiving services and/or parent(s)/legal guardian(s). Those responsibilities include, but are not limited to:

- Giving clear, accurate, appropriate information to all service providers
- Complying with program rules and regulations
- Complying with regulations concerning financial relationship with the agency
- Informing the agency of changes in address, telephone number, e-mail and other necessary demographic information
- Being actively engaged in treatment and compliant with the recommendations of the treatment team

Also during the initial assessment, appropriate Consents to Release/Obtain Information are discussed, reviewed, and signed. If the individual seeking services has received prior mental health treatment/care in another setting or from another provider, the intake therapist will request that the individual and/or the parent(s)/legal guardian(s) give permission for Community Counseling Services to request records from the previous provider(s). 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 therapist will attempt to secure a release form to obtain these records. If the individual and/or parent(s)/legal guardian(s) to not consent to CCS requesting these records, the therapist will document his/her attempts to obtain permission. Copies of the request(s) for the release of information and any special education evaluation results received will be maintained in the C&E section of the medical record. For individual who are court order to treatment by the court system, a consent form permitting information to be released to the court must be obtained. Otherwise, the intake/initial assessment process is the same as procedures identified above.

At the time of intake, individuals seeking services and/or his/her parent(s)/legal guardian(s) will be provided information regarding hours/days of operation and information regarding Community Counseling Services holiday schedule for which outpatient offices are closed. CCS has sufficient providers to ensure that a waiting list is not necessary, thus individuals are able to receive intakes within necessary time frames. If during the initial assessment it is determined that the individual is not appropriate for the services of CCS, he/she will be referred to an appropriate service provider. The intake therapist will provide referrals for appropriate facilities/providers to meet the individual's needs and will facilitate assisting the individual in making contact with the appropriate service provider during the initial assessment process when possible and with appropriate consents. All attempts, referrals, and follow-up contact will be documented.

Mississippi Operational Standards addressed: Rule 16.1, 16.2B4-11, 16.9

Section:	General Services
Policy:	Outpatient Therapy Services
Policy No.:	GS 02
Effective:	10/01/2002
Revised/Approved:	03/28/2017

POLICY: It is the policy of Community Counseling Services to offer individual, group and family therapy to adults and children/youth throughout the region. Services are offered in Community Counseling Services offices, schools, homes or other settings. Counties covered by Region 7/CCS include Choctaw, Clay, Noxubee, Lowndes, Oktibbeha, Webster, and Winston.

PURPOSE: To facilitate the mental health treatment of adults with serious mental illness and children/youth (up to age 21) with severe behavioral and/or emotional disorders throughout the region

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

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

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

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

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

Service Availability: It is the responsibility of the County Administrators/Supervisor to ensure that Outpatient Psychotherapeutic services are available and accessible at appropriate times and places to meet the needs of the population to be served. Services are available in all counties from 8:00 a.m. – 5:00 p.m. Monday – Friday and evening/weekends as available/needed. Services are available in the county office of each county served, as well as, in the City/County school system. The County Administrators/Supervisor will assure that a regular schedule, with a minimum of three (3) hours weekly for the provision of Outpatient Psychotherapeutic services during evenings and/or weekends. These days/times vary by county served and are maintained in each of the county offices.

A variety of techniques and interventions are used in the treatment of mental health related issues and are individualized to the individual/family being served. Providers using Evidence Based Practices (EBP) or best practices in the provision of Outpatient Psychotherapeutic Services must show verification that staff members utilizing those practices have completed appropriate training or independent study as recommended by the developers of the model/practice for the practices being utilized. Training completed in specific EBP's will be maintained in the employee's personnel file.

It is the responsibility of the County Administrator/Supervisor to ensure that at least one outpatient therapist for children/youth is offered to each public school district in the region served. If the school district does not accept the provider's offer to provide outpatient psychotherapeutic services, written documentation of the denial (for the current school year) by the school district superintendent is on file at the CMHC for review by DMH personnel.

There must be written policies and procedures for:

- Admission (OFM 02)
- Coordination with other services in which the individual is enrolled (CI 10)
- Follow-up designed to minimize dropouts and maximize treatment compliance
- Therapist assignments (OFM 02)
- Referral to other appropriate services as needed (CI 08)
- Discharge planning (CI 02)

Outpatient Mental Health does not maintain a waiting list. All individuals seeking admission/readmission are seen within a matter of days from referral. Staff in each county office regularly maintains contact with the Department of Human Services, the Health Department and other agencies/service providers who may serve as referral sources for adults/children/youth needing mental health services.

Services for target populations:
Individuals with mental health issues are eligible for a full range of services at Community Counseling Services, from the least restrictive individual, group, and family therapy through community support/peer support services, day treatment, supported/supervised living, as well as referrals for needed non-mental health services. Outreach is accomplished through all direct care staff, as well as, agency marketing efforts which include, but are not limited to, staff contributions to newspapers, radio

and television public service programming and frequent speaking engagements to church groups, civic clubs, interagency councils, etc.
Individuals with co-occurring disorders (SMI/SU/IDD) are also eligible for a full range of services in both diagnostic areas. Individuals with co-occurring disorders are given careful consideration by the treatment team(s) so that a full range of services is designed to meet all the mental health and substance use treatment needs of the individual receiving services. Outpatient and residential substance use treatment is available within the agency for both adolescents and adults. Collaborative relationships are maintained and referral may be made for inpatient substance use treatment if necessary.

Any individual who is a Community Counseling Services recipient of services who has been receiving inpatient/residential, institutional, or crisis stabilization unit (CSU) care is followed by his/her therapist and/or community support specialist during the inpatient treatment. When the individual is to be released, appointments are made by Community Counseling Services for mental health services within two (2) weeks of release. The therapist/CSS will insure that the individual receiving services and/or his/her family/ guardian has a telephone number which may be called to arrange appointments. Following the initial appointment, the individual's case will be staffed by the treatment team to determine appropriate services for the individual post inpatient care. An addendum to the individual service plan will be made and presented to the treatment team in staffing as indicated. An appointment is arranged with the physician within fourteen (14) days after referral/release from inpatient, institutional, CSU treatment.

Individuals being released from inpatient/residential, institutional, or crisis stabilization unit (CSU) care who have not previously received services from Community Counseling Services will be given an appointment, arranged by the inpatient facility prior to discharge, for an intake within two (2) weeks of referral. Following the initial appointment, an individual service plan will be developed and presented to the treatment team in staffing to determine appropriate services for the individual. An appointment is arranged with the physician within fourteen (14) days after referral/release from inpatient, institutional, CSU treatment. Community Support Services will be offered/provided during this time frame unless the individuals refused in writing.

All efforts will be made to serve individuals with mental illness who are homeless. Community Counseling Services therapists/community support specialists will work with community/social service agencies to deal with housing and other non-mental health issues. In communities where homeless coalitions are in existence, CCS staff will attempt to become a member to ensure homeless individuals with mental illness get referred to appropriate mental health care.

<u>Criteria for Admission</u>: Admission/readmission procedures are addressed in policy OFM 02. Criteria for adults include, being eighteen (18) years of age or older, having a psychiatric disorder which is classified in the most current edition of the Diagnostic and Statistical Manual of Mental Disorders(DSM), and impairment in basic living skills, instrumental living skills, or social functioning. The individual should be able to exhibit adequate control over his/her behavior and is judged not to be immediately dangerous

to self or others which would warrant on more restrictive level of care. The same criteria apply for children and youth who are between the ages of birth and eighteen years of age. Individuals between the ages of 18 and 21 may be served by children/youth services dependent on diagnosis, presenting problems, and identified needs are more appropriately aligned with children/youth services.

Service Determination: The treatment team, with input from the individual receiving services and his/her family, will make recommendations regarding appropriate services. Upon approval of the individual service plan, referrals to other agency services will be made, as well as, recommended services provided by other agencies. The treatment team for the individual receiving services will be made up of those individuals responsible for providing services as outlined on the individual service plan.

Children/Youth Specific: If mental health services are provided in a school setting, CCS maintains a current written interagency agreement(s) (including a confidentiality statement) signed by the Executive Director of CCS and the superintendent of the school district that at a minimum:

- 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.

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

The County Administrator/Supervisor of each county is responsible for maintenance of the Interagency Agreement maintained with each school district in his/her county. A copy of the agreement will also be maintained in the Administrative Office.

Mississippi DMH Operational Standards addressed: Rule 16.5 I, 22.1

Section: General Services
Policy: Peer Support Services
Policy No.: GS 03
Effective: 07/01/2012
Revised/Approved: 3/27/2018

POLICY: It is the policy of Community Counseling Services to provide Peer Support services throughout the region to allow consumers of mental health services and their family members the opportunity to direct their own recovery and serve as a consumer advocate.

PURPOSE: To incorporate services that are consumer and family-centered in which consumers actively participate in selecting services and developing individual service plans while working toward recovery. Services are designed and include person-centered activities with a rehabilitation and resiliency/recovery focus.

PROCEDURE: Peer Support Services are person-centered activities with a rehabilitation and resiliency/recovery focus that allow consumers of mental health services and their family members the opportunity to build skills for coping with and managing psychiatric symptoms and challenges associated with various disabilities while directing their own recovery. Natural resources are utilized to enhance community living skills, community integration, rehabilitation, resiliency and recovery. Peer Support is a helping relationship between peers and/or family members that is directed toward the achievement of specific goals defined by the individual. It may also be provided as a family partner role.

Peer Support Services are voluntary. Individuals and/or their legal representatives must be offered this services when indicated as necessary to promote recovery and resiliency by a mental health professional and/or physician. These services are provided one (1) on one (1) or in groups. When rendered in groups the ratio of staff members to individuals receiving the service is, at a minimum, one (1) staff member to eight (8) individuals.

Peer Support Services are included in and coordinated as a part of the Individual Service Plan when indicated that the individual would benefit from this recover/resiliency support. A specific planned frequency for service is identified by the individual receiving services and his/her therapist. The intensity of service is reflected on the Individual Service Plan, and subsequently approved on the plan of care. Peer Support Services are supervised by a mental health professional that has completed the DMH required peer supervisory training.

Certified Peer Specialists may be employed as part-time or full-time staff members, depending on agency capacity, the needs of the community being served, and the preferences of the employee. Documentation must be maintained that the Certified Peer Support Specialist has successfully completed a DMH recognized peer training program geared towards increasing knowledge of the CPSS about the population he/she will be supporting. Community Counseling Services employs more than one Certified Peer

Specialist and employs Certified Peer Specialists who reflect the cultural, ethnic, and public mental health experiences of the people with whom they work.

Community Counseling Services has developed and implemented a service provision plan that addresses the following:

- The population to be served, including the expected number of individuals to be served, diagnoses, age, and any specialization
- The type 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
- 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
- A description of how the mental health professional will maintain clinical oversight of Peer Support Services, which includes insuring that services and supervision are provided consistent with DMH requirements
- 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
- A description of how the Certified Peer Specialists 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
- A description of how Community Counseling Services will recruit and retain Certified Peer Support Specialists

Peer support services include activities that assist individuals in the areas of home, health, community and purpose. Activities are designed to support goals of the individual's documented Individual Service Plan and/or Wellness Recovery Action Plan (WRAP). Activities may include, but are not limited to, individual wellness and recovery/resiliency, education and employment, crisis support, housing and community living, social networking, development of natural supports, self-determination, and self-advocacy. The role of the Certified Peer Support Specialist Professional can be categorized as follows:

Resource Facilitator: Provide side by side support, coaching and encouragement to help clients socialize and access needed resources/services.

Mentor: Serve as a mentor to individuals to promote hope and empowerment.

Supporter: Peer counseling and support to validate individual's experiences and to provide guidance and encouragement to individuals to take responsibility and actively participate in their own recovery.

Recovery Advocate: Assist non-consumer staff members in recognizing and supporting possibilities and wants of individual, even when those wants and desires may seem improbable. The peer advocate believes in the individual's hopes and dreams and

communicates on behalf of the individual to others that may be hesitant about the individual's ability to obtain them.
Peer Support Services will provide one-on-one support with the following populations and in the following programs. Activities will include, but are not limited to:

SMI, SED, IDD, SU populations: Certified Peer Support Specialist Professionals (CPSSP) will serve as mentors to individuals and promote hope and empowerment. They will provide support to validate individuals' experiences and to provide guidance and encouragement for individuals to take responsibility and actively participate in their own recovery. CPSSP will work with families to understand the hopes and wants of the individual and advocate for families to support the individual in reaching specific goals and in striving to reach their hopes and dreams.

Psychosocial Rehabilitation (PSR): Certified Peer Support Specialist Professionals (CPSSP) will participate in outreach and engagement activities which will include meeting with potential new participants, as well as, participants that have been absent from the program or have been disengaged. CPSSP will also provide support to validate individuals' experiences and to provide guidance and encouragement for individuals to take responsibility and actively participate in their own recovery.

Residential (SU): Certified Peer Support Specialist Professionals will assist individuals in identifying and providing support to participate in self-help (mutual support) groups, assistance in accessing needed resources/services, and support vocational choices individuals make and assist them in overcoming job-related anxiety.

Certified Peer Support Specialist Professionals will also offer groups for populations/programs identified. When groups are provided, the ratio of staff to individuals receiving services will be a minimum of one staff member to eight (8) individuals. Topics will include, but are not limited to:

- Sharing their unique insight into mental illness
- Identification of natural/community support systems
- Teach problem solving techniques
- Teach individuals how to identify and combat negative self-talk and overcome fears
- Social skill building that will assist in job acquisition, as well as, developing support systems
- Identification of recovery goals and relapse triggers

Peer Support Services will be under the supervision of a mental health professional who has received and completed peer supervisory training offered/approved by DMH. To ensure that the CPSSP receives adequate supervision and support, the following will be incorporated, 1) Peer Support Supervisors (PSS) will provide opportunities to meet with Certified Peer Support Specialist Professionals (CPSSP) quarterly as a group to provide supervision, guidance, support, and training. The PSS can be reached by telephone to provide support and consultation for CPSSP at any time. This will help ensure that quality services are being provided in compliance with DMH Operational Standards. 2) Peer Support Supervisors (PSS) will support CPSSP in attending trainings outside the agency that will allow them the opportunity to meet with other Peer Specialists for consultation and support. 3) Peer Support Supervisors (PSS) will work with CPSSP

under their supervision to identify training needs and to develop an individual training plan based on the primary population/program for which the CPSSP will be working. The PSS will support the CPSSP in obtaining required continuing education as defined by DMH.

Peer Support Services will be provided in conjunction with other recommended mental health services as identified on the Individual Service Plan. However, no more than one service can be provided to the same individual at the same time. Each CPSSP will participate within the normal staffing patterns of the office location in which they provide services.

Certified Peer Support Specialist Professionals (CPSSP) will be available in each county served by Community Counseling Services. Ideally, there will be a minimum of one (1) Peer Support Specialist in each county. County Administrators/Supervisors and the Personnel Officer will engage in on-going identification of individuals that would be a possible candidate to function in the role of a Peer Support Specialist. Consideration will be given to individuals that are willing to self-identify as a former or current consumer of mental health services or as a first degree family member, parent, or primate caregiver. Individuals who report a period of sustained recovery, as well as, actively working towards goal on his/her Wellness Recovery Action Plan would be individuals considered for Peer Support positions. Efforts will be made to employ CPSSPs that reflect the cultural, ethnic, and public mental health service experiences of the people with whom they will work. The target populations will be individuals receiving services with an SMI, SED, IDD, or SU diagnosis.

Mississippi DMH Operational Standards addressed: Rule 42.1, 42.2

Section: General Services
Policy: Targeted Case Management Services
Policy No.: GS 04
Effective: 07/01/2012
Revised/Approved: 3/28/2017

POLICY: It is the policy of Community Counseling Services to provide targeted case management services throughout the region to ensure that services are coordinated and tasks assigned to treatment team members are completed efficiently to help individuals maintain his/her highest possible level of functioning.

PURPOSE: Targeted Case Management is a service designed to improve the quality of life and highest possible level of independent functioning for enrolled individuals.

PROCEDURE:
General Guidelines: Targeted Case Management Services is defined as services that provide information/referral and resource coordination for individuals and/or his/her collaterals. Case Management Services are directed towards helping the beneficiary maintain his/her highest possible level of independent functioning. Targeted Case Managers (TCM) monitor the individual service plan and insure team members complete tasks that are assigned to them, that follow up and follow through occur, and help identify when the treatment team may need to review the service plan for updates if the established plan is not working.

Targeted Case Management provides the following four (4) main service activities:

- Provide information/referral to appropriate Community Counseling Services (CCS) programs/services, as well as necessary community resources.

- Provide resource coordination for treatment team members and collateral contacts that are involved in the overall treatment/care of the individual.

- Monitor individual service plans to ensure that team members complete tasks assigned and that appropriate follow through occurs.

- Identify when the individual service plan needs to be reviewed and updates need to be made if the established plan is not working.

Targeted Case Management can be provided face to face or via telephone. Services can be provided in the CMHC office or in locations other than the office, such as the community, school, or home setting. Targeted Case Management services will be provided based on the complexity of the individual's case and individual needs of individuals assigned, but will be delivered no less than on a monthly basis. Targeted Case Management services must be reflected and approved on the Individual Service Plan and in some instances, requires a prior authorization in order to get reimbursed for services provided. Billable services are limited to 2 fifteen minute units/day. Caseloads will not exceed one hundred (100) individuals receiving services.

Referral Procedures: Only individuals receiving services who have a diagnosis which is considered to be eligible for classification as Serious Mental Illness or Severe Emotional Disturbance, as defined by the current version of the Diagnostic and Statistical Manual (DSM) will be considered for targeted case management. In addition to having an eligible diagnosis, the individual receiving services must meet the criteria for functional impairment in basic living skills (eating, bathing, dressing, etc.), instrumental living skills (maintenance of a household, management of money, ability to get around in the community, taking prescribed medications, etc.), and/or Social functioning (ability to function with family, in vocational/educational and/or other social contexts). If during the intake/initial assessment, the clinician determines that targeted case management could assist the individual in reaching his/her greatest level of independent functioning, the clinician will recommend to the individual receiving services and the treatment team the need for targeted case management. If accepted, targeted case management will be identified as a needed service on the individual service plan.

The referring staff member will complete and submit a referral form and forward to the targeted case manager assigned to the county in which the individual receiving services accesses services. If there is more than one targeted case manager for a particular county, the referring staff member will forward the referral to the County Administrator/Supervisor so it can be assigned as appropriate.

Delivery of Services: An established job description identifies the essential functions/duties of the Targeted Case Manager. Individuals receiving service will be assigned to the caseload of a particular TCM and/or a Mental Health Therapist who meets the qualifications to provide TCM and is approved to do so by his/her County Administrator/Supervisor. Targeted case managers will provide services according to the Operational Standards of the Department of Mental Health and CCS's Policy and Procedure Manual. Targeted case managers will determine the needs of individuals receiving services that are assigned to their caseloads. The frequency of targeted case management will be determined based on the complexity of the individual receiving services presenting issues, but not less than monthly.

Targeted Case Management services are designed to coordinate the activities of all providers, members of the treatment team, and community agencies/resources on behalf of a given individual receiving services. The targeted case manager is responsible for monitoring the individual service plan, ensure that tasks assigned are being completed, and make recommendations to update the plan if the current plan is not working. Targeted case managers will meet, when feasible, with service providers outside the agency to determine the role of those service providers in the care of the individual receiving services when appropriate release forms have been signed. Targeted case managers will be familiar with all local resources and will work to establish relationships with key contacts in each agency. TCM will report to the County Administrator/Supervisor and treatment team all barriers and constraints to the accessing of resources needed by individuals on their caseloads, thereby providing documentation of the need for services in this region.

Mississippi DMH Operational Standards addressed: Rule 18.1, 18.2

Section: Adult Mental Health

Policy: Community Support Services
Policy No.: GS 05
Effective: 04/01/1996
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services to provide Community Support Services for all adults with serious mental illness, children with severe emotional disturbance and/or individuals with intellectual and developmental disabilities who desire to receive such service and who meet all eligibility requirements.

PURPOSE: To ensure that individuals receiving services are able to make maximum progress toward improvement in social, functional and instrumental skills by means of specific, measurable, and individualized services to each person served.

PROCEDURE: Community Support Services provides an array of support services delivered by community-based, mobile Community Support Specialists directed toward adults, children, adolescents, and their families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. The purpose/intent of CSS is to provide specific, measurable, and individualized services to each person served. CSS is focused on the individual's recovery and ability to succeed in the community; to identify and access needed services, and to show improvement in work, family, and community integration. Community Support Services shall include the following:

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

General Information: County Administrators/Supervisors are responsible for the supervision and direction of Community Support Services and are responsible for overseeing the training and clinical activities of the Community Support Specialists. Caseloads of Community Support Specialists will not exceed eighty (80) individuals receiving services. It is the responsibility of the County Administrator/Supervisor to monitor the caseloads of CSS staff under his/her direction and to ensure that individuals receiving Community Support Services are assigned a single, full-time, credentialed Community Support Specialist (PCCSS or CCSS). CSS caseloads will be maintained and are available for review by Department of Mental Health staff upon request.

Community Support Services should be offered/provided within thirty (30) days of the Initial Assessment if the assessment indicates a need for such, unless the individual states, in writing, that he/she does not want to receive the service. The following priority groups must be offered/provided CSS within fourteen (14) days of the date of his/her Initial Assessment unless the individual states, in writing, that he/she does not want to receive the service:

- Individuals discharged from an inpatient psychiatric facility
- Individuals discharged from an institution
- Individuals discharged or transferred from Crisis Stabilization Services
- Individuals referred from Emergency/Crisis Response Services

Frequency of services should be based on the need(s) of the individuals receiving services. The level of need should be justified on the Individual Service Plan, in conjunction with the Recovery Support Plan. The following identifies a general expectation of when services should be provided based on the individual's level of need:

- High intensity: at least once a week
- Moderate intensity: at least twice a month
- Low intensity: at least once a month
- Follow-along: based on individual needs, but not less than every three months

Procedure for making referrals to Community Support Services: Any staff member may make a referral to Community Support Services. The individual receiving services can also request this service at the time of intake/initial assessment. Referral services outside of Community Counseling Services can also make referral; however, the individual must be assessed to determine if he/she is eligible to receive services. Community Support Services must be offered, at a minimum, every twelve (12) months during the time the individual is enrolled in services through the CMHC. Each time Community Support services are offered and refused, documentation must be maintained in the individual's chart, including refusal of this service. This includes individuals who are referred to the CMHC and fall into one of the priority groups identified above.

The referring staff member completes a Program/Services Referral Form at the time CSS are requested, sending the form to the appropriate Community Support Specialist, with the form subsequently being submitted to the medical records department to be filed. If

a staff member does not know the appropriate CSS to give the referral to, he/she will submit the form to the County Administrator/Supervisor or present at the next staffing/treatment team meeting so a determination can made about who the referral shall be given to. If an individual is referred to CSS and is not a current recipient of services, assistance will be provided in scheduling an intake/initial assessment to be performed to determine eligibility.

Eligibility: The individual receiving services must have a diagnosis which is considered to be eligible for classification as a serious mental illness or severe emotional disturbance as defined by Department of Mental Health. In addition to having an eligible diagnosis, the individual receiving services must meet the criteria for functional impairment in one of the following major life areas:

- Basic living skills (eating, bathing, dressing, etc.)
- Instrumental living skills (maintenance of a household, management of money, ability to get around in the community, taking prescribed medications, etc.)
- Social functioning (ability to function with family, in vocational/educational and/or other social contexts)

Admission to Community Support Services: Community Support Specialists have 30 days from the date of intake/initial assessment and referral (14 days for priority groups) to complete an assessment and begin providing Community Support services. Documentation of admission of individual receiving services to Community Support Services is accomplished by completion of the Service Termination/Change form. Once completed, this form should be turned into medical records to be entered into the system and filed. It is the responsibility of the assigned CSS to validate that the individual service plan reflects the areas identified on the Recovery Support Plan, includes the services to be provided by CSS staff, and that CSS services are indicated on the ISP.

Upon referral, the Community Support Specialist will schedule a time with the individual receiving services (and his/her family as applicable) for the following activities to be completed:

- Explanation of Community Support services
- Gather information to be included in the Recovery Support Plan (to be completed within 30 days)
- Individual/guardian signature on Authority to Release/Obtain Information form(s) as applicable
- Review individual rights as a recipient of services delivered by Community Counseling Services personnel

If upon referral, the individual refuses Community Support Services, the staff member should document refusal in the medical record. Should the Community Support Specialist be unable to locate the individual within the specified timeline, the Community Support Specialist shall document attempts to reach the individual, including consultation with other service providers at Community Counseling Services who serve the individual. The assigned Community Support Specialist shall send a letter to the last known address of the individual receiving services, requesting an

appointment and stating that failure to respond to the letter within two weeks will be considered a refusal of Community Support Services. A copy of the letter shall be included in the chart of the individual receiving services.

Delivery of Community Support Services:
Community Support Specialists will determine the needs of individuals receiving services on their caseloads based on the completion of the Recovery Support Plan. This plan is to be completed in conjunction and with input from the individual receiving services. The Recovery Support Plan must be completed within thirty (30) days after admission to Community Support services and must include needs identified from the ISP, long term goals, and objectives that recovery goals. The plan shall be revised as need, but rewritten at least every twelve (12) months with input from the individual receiving services and/or his/her family.

Community Support Specialists will deliver services according to the Operational Standards of the Department of Mental Health, as well as, in compliance with CCS' Policy and Procedure Manual and the CSS job description. Community Support Specialists have on-going responsibilities for individuals on their assigned caseloads regardless of the individual's other program involvement and are accessible and available at appropriate times and places to meet the needs of the individual receiving services. The frequency of a Community Support Specialist's contact with each individual receiving services is based on the needs of the individual receiving services, but shall not be less than once every three (3) months.

Community Support Specialists are responsible for being familiar with other community agencies/resources to be able to assist/coordinate the delivery of other services outside Community Counseling Services. Community Support Specialists will take steps to familiarize themselves with service providers outside the agency to determine the role of those service providers. CSS staff in each county will maintain a current, comprehensive file of available formal and informal supports. Resource information will also be maintained to include agency name, telephone number, contact person, services/supports available, and eligibility requirements. Electronically maintained resource information is permissible.

Community Support Specialist will make efforts to visit local human service agencies and will be accountable for knowledge of the guidelines, policies, and application procedures for each agency in order to facilitate optimal service delivery for individuals receiving services. CSS staff will report to the County Administrator/Supervisor all barriers and constraints to the accessing of resources needed by individuals on their caseloads, thereby providing documentation of the need for services in this region.

Coordination of Services: CSS are responsible for assisting individuals in accessing needed services such as medical, social, educational, transportation, housing, substance abuse, personal care, employment and other services to ensure that needs identified on the ISP and Recovery Support Plan are addressed. CSS will inform individuals receiving services of community resources, assist individuals receiving services in making application for needed resources, and follow-up with agencies to ensure appropriate service delivery. A Community Support Specialist may accompany

an individual receiving services to an appointment with a service provider/agency **only** if the therapeutic necessity of the Community Support Specialist's presence is clearly documented. Any Community Support Specialist assisting a child/youth visiting a medical/dental service provider/agency outside Community Counseling Services must be accompanied by the parent/guardian. In emergencies/special circumstances, any exception to this policy must be approved by the County Administrator/Supervisor.

Monitoring and evaluation of services: Monitoring of service refers to activities which ensure that an individual is receiving services which have been identified as needed, that such services are addressing the individual's needs, and that no barriers exist to accessing needed resources. Should contacts with the individual receiving services reveal additional needs or barriers in accessing resources, the Community Support Specialist is then responsible for addressing such shortcomings with the County Administrator/Supervisor and/or the interdisciplinary treatment team in the county. The Community Support Specialist will regularly evaluate service delivery to determine its effectiveness and will make revisions and adjustments in the service providers or delivery system based on the needs and progress of the individual receiving services. When possible, Community Support Specialists will involve the families of individuals receiving services in monitoring and evaluation of service provided to aid the individual receiving services in reaching his/her goals. For adults, necessary Authority to Release/Obtain Information forms will be obtained from the individual receiving services prior to any communication with his/her family.

Direct intervention in deescalating situations to prevent crisis: All Community Support Specialists are required to attend and successfully complete a Crisis Prevention Intervention course which provides training on how to intervene verbally and physically when warranted, to deescalate potential crisis situations. The methods taught in this workshop are to be used in the event a Community Support Specialist must intervene in a potential crisis situation. Techniques will be used in an effort to de-escalate the situation and ensure the care, welfare, safety and security of all individuals involved. In the event the crisis will require emergency placement, the Community Support Specialist will contact the individual's therapist and the County Administrator to discuss admission into a local psychiatric facility if deemed appropriate. When available, the staff psychiatrist will be contacted to assist with referral for admission. If no bed space is available in a local facility, the Community Support Specialist will contact a resource outside the Community Counseling Services catchment area. The individual receiving services and/or his/her family will make the final choice of the facility.

Psychiatric evaluations/med checks: Individuals receiving services and their families should be encouraged to make their own medical appointments with Community Counseling Services. When support or guidance is needed, CSS can assist in teaching the skills on how to schedule necessary appointments. When assistance is needed, the Community Support Specialist will contact the receptionist at the appropriate office to inquire about the date of the next medication clinic. If an appointment is needed due to an emergency and is in an office where the chart of the individual receiving services is not ordinarily located, arrangements must be made to have the chart accessible by the medical provider in the office where he/she is located. The Community Support

Specialist will accompany the individual receiving services to medication clinics as requested by the psychiatrist/PMHNP and/or his/her supervisor.

Discharge from Community Support Services: If the goals and objectives identified on the Recovery Support Plan have been met and there is no additional needs identified, the individual will be discharged from CSS services. A final contact with the individual will address completion of goals outlined, as well as, identifying other support available if needed. Individuals receiving services not seen for more than ninety (90) days should be contacted to determine whether or not he/she wishes to continue receiving Community Support Services. Efforts to contact the individual must be documented. Individuals who cannot be contacted after diligent effort to locate them shall have their cases submitted to staffing to determine if the case should be discharged from all services or if the individual should be terminated from CSS services only. If the individual is being terminated from CSS services only, the Service Termination/Change form should be completed and turned in to medical records so it can be entered in to the system and subsequently filed. If the individual is being discharged from all CCS services, the Provider Discharge Summary shall be completed and submitted to medical records.

Community Support Services for Children/Youth with SED:
The following identifies specific rules related to CSS staff providing services to children/youth:

- Input from the parent(s)/legal representative(s) in the development of the Recovery Support Plan for children/youth must be documented.
- The case load for a single Community Support Specialist providing services to children, youth, and transition-age youth enrolled in federal System of Care grants must not exceed twenty-five (25).

Community Support Services for Individuals with Intellectual/Developmental Disabilities – Adults and Children:
The following identifies specific rules related to CSS staff providing services to individuals with Intellectual/Developmental Disabilities:

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

Mississippi Operational Standards addressed: Rule 20.1