Section: General Services
Policy: Initial Assessment/Eligibility
Policy No.: GS 01
Effective: 01/01/1997
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) that all persons 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). CCS assures equal access to treatment and service and non-discrimination based on ability to pay, race, sex, age, creed, national origin, or disability for people who meet eligibility criteria.

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

PROCEDURE: All persons 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 with serious mental illness, children/youth with serious emotional disturbance and people 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 Residential Services
- Individuals referred from Crisis Response Services

The initial assessment shall be conducted in any CCS office 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 primarily 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 receipts can be given for any payment received. For people whose third-party payer/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 person to come to the office for the intake. This can also include conducting the intake via telehealth. 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 and consent can be given for services. 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 people receiving mental health services and/or substance use disorders services, the initial and any subsequent assessments are face-to-face contacts (including telehealth) with the purpose of securing information from the person and/or collateral contact regarding: 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 person's mental health issue, the factors contributing to the problem(s), and the most appropriate course of treatment for the person. 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 severe 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 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 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

<u>SMI/SED/IDD Determination:</u>

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 Diagnostic and Statistical Manual of Mental Disorders (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 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

All people interested in IDD services must first be determined eligible through an evaluation by the Diagnostic and Evaluation Team at one of the State's ICF/IID Regional Programs. 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)

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

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

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.

For **adults receiving substance use disorders service**, the following DMH approved functional assessment will be completed within timelines according to the service rendered:

- 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 people 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 person'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 person's case record verifying the assessment(s) was administered, with documentation of follow-up of results if applicable, during substance use treatment 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.

Psychiatric/Physician Services:
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 person 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 person and/or parent(s)/legal guardian(s) about the individual's rights, he/she also explains the responsibilities of the person 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 people 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, people 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 people are able to receive intakes within necessary time frames. If during the initial assessment it is determined that the person 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 person's needs and will facilitate assisting the person 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 DMH Operational Standards addressed: Rule 16.1, 16.2.A.2d-11, 16.8

Section: General Services
Policy: Outpatient Therapy Services
Policy No.: GS 02
Effective: 10/01/2002
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to offer individual, group and family therapy to adults and children throughout the region. Services are offered in CCS offices, schools, homes or other appropriate settings, including the use of telehealth when authorized. 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 with serious emotional disturbance (up to age 21).

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 Addictions therapist (as appropriate to the population being served) and a person, 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 person receiving services.

Family Therapy: psychotherapy that takes place between a mental health therapist and an person'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 people receiving services, with or without the presence of the person, directed toward the reduction/resolution of identified mental health problems so that the person and/or their 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 (CA) to ensure that Outpatient Psychotherapeutic services are available and accessible at appropriate times and places to meet the needs of the population 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 CA will ensure 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 person/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 CA 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 Psychotherapeutic Services does not maintain a waiting list. All people seeking admission/readmission are seen within a matter of days from referral. CA's are responsible for ensuring other community agencies/referral sources are aware of available services and how to make referrals.

Services for target populations:
People with mental health issues are eligible for a full range of services at CCS, including individual, group, and family therapy, 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 frequent speaking engagements to church groups, civic clubs, interagency councils, etc.

People 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 person. Intensive outpatient and residential substance use treatment is available within the agency for adults. Collaborative relationships are maintained and referral may be made for inpatient substance use treatment if necessary.

Any person receiving outpatient services through CCS and is subsequently admitted to an inpatient, residential, institution, or Crisis Stabilization Unit (CSU) will continued to be followed by his/her therapist and/or community support specialist. When the individual is ready for discharge, appointments are made as soon as possible, but no longer than two (2) weeks of discharge. If indicated, an addendum to the Individual Service Plan will be made and presented to the treatment team to reflect services needed/goals post inpatient care. An appointment is arranged with the physician within fourteen (14) days after referral/release from inpatient, institutional, or CSU treatment.

Persons being released from inpatient, residential, institutional, or a crisis stabilization unit (CSU) who have not previously received services from CCS will be given an appointment, arranged by the treating 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 refuses in writing.

All efforts will be made to serve individuals with mental illness who are homeless. CCS 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.

Criteria for Admission: 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 person should be able to exhibit adequate control over their behavior and is judged not to be immediately dangerous to self or others which would warrant a 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. People between the ages of 18 and 21 may be served by children/youth services dependent on diagnosis, presenting problems, and if identified needs are more appropriately aligned with children/youth services.

Service Determination: The treatment team, with input from the person/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 person will be made up of those individuals responsible for providing services as outlined on the Individual Service Plan.

The agency provider must initiate and maintain the standardized Memoranda of Understanding (MOU), including a confidentiality statement, signed by the Executive Officer of the mental health agency provider and the superintendent of each school district in the region served by the agency provider. The CA 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 J, 22.1

Section: General Services
Policy: Peer Support Services
Policy No.: GS 03
Effective: 07/01/2012
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to provide Peer Support services throughout the region to allow persons receiving mental health/substance use services and their family members the opportunity to direct their own recovery.

PURPOSE: To incorporate services that are person and family-centered in which people actively participate in selecting services and developing their Individual Service Plan while working towards recovery. Services are designed and include person-centered activities that are non-clinical, with a rehabilitation and resiliency/recovery focus.

PROCEDURE: Peer Support Services are person-centered, non-clinical activities with a rehabilitation and resiliency/recovery focus that allow people receiving 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. People 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 person 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.

A Certified Peer Support Specialist Professionals (CPSSP) is a person with lived experience who has successfully complete peer support competencies-based training and testing. CPSSP 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. CCS 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.

There are the following CPSSP designations:

- Certified Peer Support Specialist Professional – Adult (CPSSP-A)
- Certified Peer Support Specialist Professional – Parent/Caregiver (CPSSP-P)
- Certified Peer Support Specialist Professional – Youth/Young Adult (CPSSP-Y)
- Certified Peer Support Specialist Professional – Recovery (CPSSP-R)

CPSSP must provide services according to their lived experience and designation.

CCS has developed and implemented the following service provision plan ~~that addresses~~ 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 CPSSP 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 person's experiences and to provide guidance and encouragement to people 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 people, even when those wants and desires may seem improbable. The peer advocate believes in the person's hopes and dreams and communicates on behalf of the person to others that may be hesitant about the person'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:

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

<u>Psychosocial Rehabilitation (PSR)</u>: 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 people's experiences and to provide guidance and encouragement for people to take responsibility and actively participate in their own recovery.

Residential (SU): Certified Peer Support Specialist Professionals (CPSSP) will assist people 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.

System of Care (SOC) - Certified Peer Support Specialist Professionals (CPSSP) will assist youth/young adults in regaining control over their lives and establishing personal recovery goals. CPSSP will provide assistance in obtaining necessary services/resources, model a sense of hope and resiliency, encourage participation in system activities, and promote awareness and acceptance of mental health issues.

CPSSP will also offer groups for populations/programs identified. When groups are provided, the ratio of staff to participants 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. PSS will supervise no more than 9 CPSSP (FTE). PSS must report ethical violations and changes in employment to DMH, Division of Recovery and Resiliency. To ensure that the CPSSP receives adequate supervision and support, the following will be incorporated:

- A designated 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.
- PSS can be reached by telephone to provide support and consultation at any time. Newly hired CPSSP will receive bi-weekly supervision for the first 6 months of employment, monthly for months 7-12, and as deemed necessary after 1 year of employment. PSS will maintain a log of supervisor meetings.
- Peer Support Supervisors (PSS) will support CPSSP in attending trainings outside the agency that will allow them the opportunity to meet with other Peer Support Specialists for consultation and support.
- Peer Support Supervisors (PSS) will work with CPSSP under their supervision to identify training needs and to develop a personal training plan based on the primary population/program for which the CPSSP will be working.
- 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 and the HR Department 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 a) people that are willing to self-identify as a former or current consumer of mental health services, b) a parent or primary caregiver of a child/youth with an emotional, social, behavioral and/or substance use disability and has received previous mental health services, c) transitional age youth with lived experience, and d) an adult with a substance use disorder who is in recovery. People 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 people 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: 6/22/2021

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 people maintain his/her highest possible level of functioning.

PURPOSE: Targeted Case Management is a service designed to assist people who reside in a community setting or are transitioning to a community setting in gaining needed medical, social, educational, and other services.

PROCEDURE:
General Guidelines: Targeted Case Management Services is defined as services that provide information/referral and resource coordination for people and/or his/her family. 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. Active participation of the person and/or the family/guardian is encouraged in determining needs and developing goals.

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, collateral contacts, and family members that are involved in the overall treatment/care of the person.

- 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 person's situation and needs of the person receiving services. 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 8 fifteen

minute units/day. Caseloads will not exceed one hundred (100) individuals receiving services.

Referral Procedures: Only people who have a diagnosis which is considered to be eligible for classification as a 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 services. In addition to having an eligible diagnosis, the person 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 initial assessment, the clinician determines that targeted case management services could assist the person in reaching his/her greatest level of independent functioning, the clinician will recommend to the person and the treatment team the need for targeted case management services. 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 person 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 so it can be assigned as appropriate.

Delivery of Services: Persons 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. Targeted case managers will provide services according to DMH Operational Standards, DOM guidelines and CCS's Policy and Procedure Manual. Targeted case managers will determine the needs of persons that are assigned to their caseloads, encouraging input and active participation from the person. ~~The frequency of targeted case management will be determined based on the complexity of the person's needs, 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 person. The targeted case manager is responsible for monitoring the Individual Service Plan, ensuring 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 person 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 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: General Services
Policy: Community Support Services
Policy No.: GS 05
Effective: 04/01/1996
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to provide Community Support Services for all adults with serious mental illness, children with severe emotional disturbance and/or persons with co-occurring issues who desire to receive such service and who meet all eligibility requirements.

PURPOSE: To ensure that people 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 person. The purpose/intent of Community Support Services is to provide specific, measurable, and individualized services to each person served. Community Support Services are focused on the person's recovery and ability to succeed in the community; to identify and access needed services, and to show improvement in home, health, purpose, and community. Community Support Services shall include the following:

1. Identification of strengths which will aid the person 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 person 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 a person 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 a person 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 person
10. Facilitation of the Individual Service Plan and/or Recovery Support Plan which includes the active involvement of the person and people identified as important in the person's life

General Information: County Administrators (CA) 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 Specialist. Caseloads of Community Support Specialists will not exceed eighty (80) individuals except for Community Support Specialists providing services to children, youth, and transition-age youth enrolled in federal System of Care grants where it is capped at twenty-five (25). It is the responsibility of the CA to monitor the caseloads of Community Support Specialists 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). Community Support Specialists' 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 Community Support Services within fourteen (14) days of the date of his/her Initial Assessment unless the individual states, in writing, that he/she does not want to receive the service:

- 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 person. 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 person can also request this service at the time of intake/initial assessment. Referral services outside of CCS can also make a referral; however, the person 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 person is enrolled in services. Each time Community Support Services are offered and refused, documentation must be maintained in the medical record, including refusal of this service. This includes people who are referred to the CMHC and fall into one of the priority groups identified above.

The referring staff member completes a Referral Form at the time Community Support Services are requested, sending the form to the appropriate Community Support Specialist. If a staff member does not know the appropriate Community Support Specialist to give the referral to, the form shall be submitted to the CA or presented at

the next staffing/treatment team meeting so a determination can made about who the referral shall be given to. If a person is referred to Community Support Services 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 person 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, person 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. It is the responsibility of the assigned Community Support Specialist to validate that the Individual Service Plan (ISP) reflects areas identified on the Recovery Support Plan, includes services to be provided, and that Community Support Services are indicated on the ISP.

Upon referral, the Community Support Specialist will schedule a time with the person (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 CCS

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

Delivery of Services: Community Support Services are accessible and available at appropriate times and places to meet the needs of the persons on his/her caseload. The frequency of contact with each person is based on the needs of the individual, but shall not be less than once every three (3) months. Community Support Specialists will determine the needs of individuals on their caseload based on the completion of the

Recovery Support Plan. This plan is to be completed in conjunction and with input from the person. For children/youth, input from the parent(s)/legal representative(s) in the development of the Recovery Support Plan must be documented.

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 recovery goals. The plan shall be revised as needed, but rewritten at least every twelve (12) months with input from the person and their family/guardian. CCS will deliver Community Support Services according to DMH Operational Standards, DOM guidelines, as well as, in compliance with CCS' Policy and Procedure Manual.

Community Support Specialists are responsible for being familiar with other community agencies/resources to be able to assist and coordinate the delivery of other services outside CCS. Community Support Specialists will take steps to familiarize themselves with service providers outside the agency to determine the role of those service providers. Community Support Specialists 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 Specialists 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. Community Support Specialists will report to the County Administrator all barriers and constraints to the accessing of resources needed by people on their caseloads, thereby providing documentation of the need for services in this region.

Coordination of Services: Community Support Specialist are responsible for assisting people 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. Community Support Specialists will inform people of community resources, assist them in making application for needed resources, and follow-up with agencies to ensure appropriate service delivery. A Community Support Specialist may accompany a person to an appointment with a service provider/agency **only** if the therapeutic necessity of the Community Support Specialists' presence is clearly documented. Any Community Support Specialist assisting a child/youth visiting a medical/dental service provider outside of CCS must be accompanied by the parent/guardian. In emergencies or special circumstances, an exception to this policy may be approved by the County Administrator or COO.

Monitoring & Evaluation of Services: Activities will be implemented to ensure that persons who have been identified as in need of Community Support Services are receiving services, that services are addressing the individual's needs, and that no barriers exist to accessing needed resources. The Community Support Specialist will regularly evaluate service delivery to determine its effectiveness and will make revisions and adjustments in the delivery system based on the needs and progress of the person. When possible, Community Support Specialists will involve the families, with

appropriate release forms, in monitoring and evaluating services provided to support the person in reaching his/her goals. For adults, necessary release forms will be obtained prior to any communication with family or other supports.

Deescalating Situations to Prevent Crisis: All Community Support Specialists are required to attend and successfully complete a Crisis Prevention Intervention (CPI) course which provides training on how to intervene verbally and physically (as a last resort), 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 requires 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. Placement at CCS' Crisis Stabilization Until will be explored first, before exploring other placements. When available, the person's psychiatrist/PMHNP will be consulted 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 of CCS' catchment area. The person and/or their family will make the final choice of placement location.

Psychiatric Evaluations: Individuals and their families should be encouraged to make their own medical appointments with CCS. When support or guidance is needed, Community Support Specialists can assist in teaching the skills on how to schedule necessary appointments by demonstrating how to contact the appropriate office to schedule an appointment. The Community Support Specialist may accompany the person to CCS medical appointments when requested by the psychiatrist/PMHN or the employee's 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 person will be discharged from Community Support Services. During the final contact, the Community Support Specialist will document completion of goals, as well as, identify other available supports if needed. People not seen for more than ninety (90) days should be contacted to determine whether or not they wish to continue receiving Community Support Services. Efforts to contact the person must be documented. People 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 person should be terminated from Community Support Services only. If the person is being terminated from Community Support Services only, the Service Termination/Change form should be completed. If the person is being discharged from all CCS services, the Provider Discharge Summary shall be completed. All discharges must be submitted to the CA for approval.

Mississippi DMH Operational Standards addressed: Rule 20.1 – 20.3

Section: General Services
Policy: Intensive Community Support Services (ICSS)
Policy No.: GS 06
Effective: 6/22/2021
Revised/Approved:

POLICY: It is the policy of Community Counseling Services (CCS) to provide Intensive Community Support Services for adults with serious mental illness and children with severe emotional disturbance who have traditionally been managed in psychiatric hospitals, possess severe functional impairments, and need intensive, person-centered services to be maintained in the community.

PURPOSE: To provide an array of intensive support services to promote independence and provide ongoing needed supports. The ultimate goal is to help people function in the least restrictive, most natural community environment and achieve an improved quality of life by obtaining their recovery goals.

PROCEDURE: Intensive Community Support Services provides a key service in the continuum of care for people with serious mental illness or emotional disturbance. Intensive Community Support Specialists (ICSS) maintain a small client/staff ratio which allows for increased frequency in service provision. If needed, people are seen multiple times per week and the majority of contacts are in the person's natural environment rather than an office setting. Through increased frequency of contact, ICSS are more likely to develop supportive, encouraging relationships with the people/families being served. ICSS are responsive to the many changing needs of people on his/her caseload and assists people in accessing needed services within the mental health system, as well as, other needed service systems.

Service Provision: Intensive Community Support Services include a) outreach and referral, b) frequent assessment and planning, c) frequent direct service provision, d) ongoing monitoring, evaluation, and follow-up, and e) information, liaison, advocacy, consultation and collaboration.

Service Requirements: The ICSS must monitor and track all people from the agency's catchment area that receive a Pre-Evaluation Screening are committed into inpatient care, or began inpatient care voluntarily. The ICSS is responsible for coordinating with people, family and the facility to develop and coordinate an aftercare plan once the individual is discharged. The ICSS(s) will serve as the primary contact ("single-point-of-entry") for inpatient facilities discharging someone into CCS' catchment area. Upon discharge, the ICSS must identify unmet needs of the person in the community and develop a plan to address those identified needs. The ICSS works closed with Crisis Response Services (M-CeRT), the Crisis Stabilization Unit, and psychiatric hospitals that discharge to CCS' catchment area. ICSS shall attend MAP/AMAP Team meetings to ensure continuity of care. The ICSS will develop the Crisis Support Plan for people on their caseload and will assist in the development of a Crisis Support Plan for those being discharged from an inpatient facility. The ICSS must coordinate with typical mental health services in the person's community in order to transition the person using the "warm hand-off method" into traditional mental health services when warranted. ICSS

and Targeted Case Managers work collaboratively when indicated to develop and coordinate each person's services.

Staffing: Staff must be assigned to Intensive Community Support Services full time and maintain a caseload maximum of 20 people for a full-time ICSS. At a minimum, services must be provided by a Bachelor's level staff member with a DMH Community Support Specialist's credential and 3 years of mental health direct care experience. The ICSS must be under the supervision of a Master's degree clinician with at least 3 years of direct mental health experience.

Mississippi DMH Operational Standards addressed: Rule 32.18