Section: Adult Mental Health
Policy:
Policy No: AMH 01
Effective:
Revised/Approved:

Reserved for future use

Section: Adult Mental Health
Policy: Services to the Elderly
Policy No: AMH 02
Effective: 04/14/1998
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to provide services to the elderly population living in the community and in personal care homes or nursing homes throughout Region 7.

PURPOSE: To ensure that the elderly population has access to needed mental health services.

PROCEDURE: Elderly individuals who meet eligibility requirements may be seen by any service provider as determined by regular assignment procedures for therapists, community support specialist, and medical services. Therapy and community support services are available within CCS offices or may be provided in the individual's home if requested/desired and clinically appropriate. In addition, CCS provides Community-based Senior PSR programs in Choctaw, Clay, Lowndes, Noxubee, Oktibbeha and Winston Counties for those individuals who meet eligibility requirements. Individuals from Webster County are eligible to attend the program in Choctaw County.

Those elderly individuals living in nursing homes within Region VII may have services provided by the therapist regularly assigned to deliver individual, group and/or family therapy in the nursing home to which the person resides. A Level II Screening must be completed and services must be authorized prior to service provision in a nursing home setting. Only those services authorized are available for residents of nursing homes.

Section: Adult Mental Health
Policy: Psychosocial Rehabilitative Services
Policy No.: AMH 03
Effective: 01/01/1997
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to provide Psychosocial Rehabilitative services for people with serious mental illness in each county.

PURPOSE: To ensure that all adults with serious mental illness have access to Psychosocial Rehabilitative Services (PSR) in order to assist them in developing and maintaining a level of functioning necessary to live meaningful and purposeful lives in the community.

PROCEDURE: Psychosocial Rehabilitative Services (PSR) consists of a network of services designed to support and restore community functioning and well-being of adults with a serious and persistent mental illness. The purpose of the program is to promote recovery, resiliency, and empowerment of the person in his/her community. Program activities aim to improve reality orientation, social skills and adaptation, coping skills, effective management of time and resources, task completion, community and family integration, vocational and academic skills, and activities to incorporate the individual into independent community living; as well as to alleviate psychiatric decompensation, confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

It is the responsibility of the CA to ensure that PSR programs utilize systematic, curriculum based interventions for recovery skills development for participants. The curriculum based interventions must be evidence-based or recognized best practices in the field of mental health as recognized by SAMHSA. Curriculum based interventions address the following outcomes for the individuals participating in PSR:

- Increased knowledge about mental illness
- Fewer relapses
- Fewer hospitalizations
- Reduced distress from symptoms
- Increased consistent use of medications
- Increased recovery supports to promote community living

The PSR systematic and curriculum based interventions address the following core components:

- Psychoeducation
- Relapse Prevention
- Coping Skills Training
- Utilizing Resources and Supports (inclusive of crisis planning)

The PSR systematic and curriculum based interventions, at a minimum, include the following topics:

- Recovery strategies
- Facts about mental illnesses
- Building social supports
- Using medications effectively
- Drug and alcohol use
- Reducing relapse
- Coping with stress
- Coping with problems and symptoms of mental illness
- Self-advocacy

Each PSR Program Leader shall hold a meeting no less than once each week in which members may communicate their desires/provide feedback regarding the operation of the program and activities aimed at reaching their personal recovery goals. Recreational and/or social activities are provided for members approximately once a month. These activities are provided outside of structured program hours.

Referral/admission: Any interested person/agency may refer an individual for PSR services. A referral should include (if available) basic identifying information and additional pertinent information such as diagnosis and level of functioning. Once the PSR Program Leader receives a referral, he/she will contact the person and arrange for a home visit to discuss the program with the interested person and their family if requested. It should be made clear to all referrals that services are voluntary. Appropriate referrals include people eighteen (18) or older, who have a SMI diagnosis. For people who pose a threat to the general safety of other program participants, the treatment team will make a determination regarding appropriateness for participation. If the treatment team determines that a person is not appropriate or poses an imminent risk to other program participants, documentation of such will be reflected in the person's medical record. PSR services must be reflected on the Individual Service Plan and a prior authorization from the Division of Medicaid, or its designee, must be obtained for people who are also Medicaid beneficiaries.

Recovery Support Plan: All people are required to have a Recovery Support Plan. People participate in setting goals and assessing their own skills and resources related to goal attainment. Goals are set by exploring strengths, knowledge and needs in the person's living, learning, social, and working environments. The plan will be developed within 30 days of enrollment to a PSR program based on the guidelines outlined in the DMH Record Guide and at a minimum will be reviewed and revised/rewritten annually. People will participate in the development of their Recovery Support Plan based on their personal recovery goals. Information included will consist of the person's definition of quality of life, desired outcomes, identification and integration of natural supports to connect to the community, and utilization of formal and informal resources to support goals and desired outcome(s). Through participation in the PSR program, each person is provided assistance in the development and acquisition of needed skills and resources necessary to achieve stated recovery goals.

Documentation: Documentation of therapeutic activities are provided in progress notes. A progress note must be entered in the record as often as necessary to document

person's response to service plan activities, but not less than weekly. Documentation must include therapeutic activities in which the individual was engaged.

General Guidelines: PSR services must be provided in each location a minimum of three (3) days per week for a minimum of four (4) hours per day. People participating in PSR services may participate in the service up to five (5) hours per day, five (5) days a week. PSR services have sufficient space to accommodate the full range of therapeutic activities and must provide at least fifty (50) square feet of space for each person. A first aid kit shall be maintained at each PSR program location in accordance with policy MC 02. PSR services are located in their own physical space, separate from other mental health center activities or institutional settings and impermeable to use by other services/programs during hours of program operation. Each program must have on site a certificate from DMH which establishes the total number of individuals who can be served at the site. Exceeding the number of individuals that the site is certified to serve is not permitted on any given day. The following Community Counseling Services PSR programs are open Monday – Friday, 8:00 a.m. to 5:00 p.m.:

- Choctaw/Webster County: 80 Old Sturgis Road, Ackerman, MS 39735
- Clay County: 99 West Jordan Avenue, West Point, MS 39773
- Lowndes County: 404 23rd Street North, Columbus, MS 39701
- Noxubee County: 166 Lawrence Street, Macon, MS 39341
- Oktibbeha County: 682 Collier Road Starkville, MS 39759
- Winston County: 769 Metts St., Louisville, MS 39339

Staff Requirements: The PSR program includes, at each site, a full time supervisor (see qualifications in Policy HR 16, Minimum Qualifications of Staff). A Director or Mental Health Therapist (see Policy HR 16) with the responsibility of therapeutic oversight is on site a minimum of five (5) hours per week. The Program Director or Mental Health Therapist plans, develops, and oversees the use of systematic curriculum based interventions implemented to address the needs of people receiving PSR services. In addition to the minimum of five (5) hours of on-site supervision, the Director or Mental Health Therapist also participates in clinical staffing for the individuals in the program that he/she directs. If the PSR Program Leader does not possess a Master's degree, then the Program Director or MH Therapist providing oversight to the PSR program must have a Master's degree in mental health and either a professional license or a DMH credential as a Mental Health Therapist.

The PSR Program Leader has predominantly supervisory and administrative responsibilities on-site in the day-to-day provision of services at a single location for Psychosocial Rehabilitative Services and has at least a Bachelor's degree in a mental health, intellectual/developmental disabilities or related field, and is under the supervision of an individual with a Master's degree in mental health or intellectual/developmental disabilities or a related field and who has either a professional license or a DMH credential as a Mental Health Therapist. PSR services maintain a minimum of one (1) qualified staff member to each twelve (12) or fewer people present in a PSR program. The supervisor may be included in this ratio.

Mississippi DMH Operational Standards addressed: Rule 24.1

Section: Adult Mental Health
Policy: Services to People with Co-Occurring Disorders
Policy No: AMH 04
Effective: 02/01/1997
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) that all people who have a mental illness and substance use disorder shall receive an appropriate combination of services from the continuum of care which will address both presenting issues so that the person's opportunities for recovery are maximized.

PURPOSE: To ensure that persons with co-occurring disorders (SMI/SUD for the purpose of this policy) and their families are accurately identified, thoroughly assessed, and engaged in appropriate treatment.

PROCEDURE: In addition to traditional mental health and substance use disorder services, CCS offers integrated treatment services for people who have a serious and persistent mental illness and a co-occurring substance use disorder. Training on co-occurring issues and treatment will be provided by the Co-Occurring Coordinator employed by CCS. Trainings will focus on assessing for both mental health and substance use issues at intake and throughout care, documentation requirements based on diagnosis identified, and evidenced based programs and practices used to treat co-occurring issues. Training will also be provided related to engaging individuals in service and developing co-occurring groups in each county served by CCS.

Co-Occurring Substance Abuse Services are the provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has individual-determined goals. Appropriate interventions/activities include, but are not limited to; 1) Engagement (e.g., empathy, reflective listening, avoiding argumentation). 2) Assessment (e.g., stage of readiness to change, individual-determined problem identification). 3) Motivational enhancement (e.g., developing discrepancies, psycho-education) 4) Active treatment (e.g., cognitive skills training, community reinforcement). 5) Continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans). Each CA will ensure that the treatment team in his/her county is providing appropriate services to people with co-occurring disorders.

All persons receiving outpatient mental health services will be assessed for substance use disorders at intake. If a substance use disorder is suspected, the person will receive further substance use disorder assessments to determine appropriate level of care. When a substance use disorder is identified, an appropriate individual service plan will be developed by the assigned therapist and will address both the mental health and substance use disorders concurrently.

CCS is utilizing the "No Wrong Door" policy, where attempts will be made to treat each person for both substance use and/or mental health issues regardless of how they attempt to utilize services. In an effort to identify accurately presenting issues, all people receiving treatment for substance use disorders through specified substance use

disorder programs (i.e., residential, intensive outpatient programs) will be assessed for serious mental illness at intake. When a serious mental illness is found, the treatment team will ensure that appropriate services are provided. All individuals with a SMI diagnosis who reside in Region VII and receive residential substance abuse treatment will be referred to the treatment team in the appropriate county upon termination of treatment, regardless if substance use treatment is successfully completed or not. The treatment team will then attempt to engage the person in outpatient services. Similarly, all individuals will be assessed for substance use disorders. If needed, the individual will be provided integrated treatment, regardless of the office they present for services. If a referral to another agency program or level of care is necessary, clinicians giving/receiving the referral will work together to ensure a seamless transition of services. Services will not be denied based on the presence of a substance use disorder or serious mental illness.

Section: Adult Mental Health
Policy: Senior Psychosocial Rehabilitative Services (Senior PSR)
Policy No.: AMH 05
Effective: 06/15/2000
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to provide psychosocial rehabilitative services to persons with Serious Mental Illness who are fifty (50) years of age or older who need assistance in socialization, training for daily living skills, use of leisure time activities, or other structured assistance in activities of life.

PURPOSE: To support and enhance the ability of the elderly with Serious Mental Illness to function at the highest level of independence in the most integrated setting appropriate to their needs.

PROCEDURE: Senior PSR provides structured activities designed to support and enhance the ability of the elderly to function at the highest possible level of independence in the most integrated setting appropriate to their needs. The activities target the specific needs and concerns of the elderly, while aiming to improve reality orientation, social adaptation, physical coordination, daily living skills, time and resource management, task completion and other areas of competence that promote independence in daily life. Activities in the program are designed to alleviate such psychiatric symptoms as confusion, anxiety, disorientation, distraction, preoccupation, isolation, withdrawal and feelings of low self-worth.

It is the responsibility of the CA to ensure that Senior PSR is designed to serve elderly persons with serious mental illness who need assistance in socialization, training for daily living skills, use of leisure time activities, or other structured assistance in activities of life. People participating in Senior PSR are involved in community activities to the maximum extent possible. Community activities are an integral part of the program, utilizing churches, parks, libraries, universities, and other community resources which are appropriate and available. Each program has a specific plan is in place to ensure that community involvement remains an important part of Senior PSR. These activities will be reflected on the monthly schedule.

General Information: No individuals under fifty (50) years of age can be considered for Senior PSR. Senior PSR programs have an average daily attendance of at least five (5) people. The program must have sufficient space to accommodate the full range of program activities and services and must provide at least fifty (50) square feet of usable space for each person. The program shall post the certificate from DMH that establishes the total capacity of each program. The capacity established cannot be exceeded.

Community Based Senior PSR programs: For programs located in a CMHC, the service is provided in each location a minimum of three (3) days a week for a minimum of four (4) hours per day, excluding travel time. In addition, medical screenings must be conducted on all individuals admitted to Senior PSR. Individuals referred to community based Senior PSR programs must have a medical screening by a licensed physician or certified nurse practitioner, including a statement from the examiner which verifies the

individual is physically able to benefit from the program and does not have any health condition that would create a hazard for other individuals or employees of the service. The result of the examination is placed in each person's record. No one will be admitted to or retained in a Senior PSR program without such required documentation.

Staffing: Staff members are assigned full time to Senior PSR. There is at least one (1) staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who must be on-site and be actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor. The staff person with a Bachelor's degree is required for eight (8) or fewer people. When the program is certified for nine (9) or more people, there must be another staff person for every eight (8) individuals. The Program Manager is designated to plan, coordinate and evaluate Senior PSR services within the county. For programs whose Program Manager is not a Master's degree clinician, an Administrator or Mental Health Therapist with responsibility of therapeutic oversight will be on site a minimum of five (5) hours per week, as well as, participate in clinical staffings for the people who participate in the program. Documentation of therapeutic oversight will be maintained on site.

Nursing home based Senior PSR programs: There is at least one staff member with a minimum of a Bachelor's degree in a mental health or intellectual/developmental disabilities or related field who is on-site and actively engaged in program activities during all programmatic hours; this staff person can be the on-site supervisor. The staff person with a Bachelor's degree is required for eight (8) or fewer people. When the program is certified for nine (9) or more people, there must be another staff person for every eight (8) individuals for whom the program is certified to serve. For programs located in a nursing home, the service is provided in each location a minimum of three (3) days per week for a minimum of two (2) hours per day, excluding travel time. DMH will accept verification of licensure from the MS State Department of Health as evidence that programs are addressing and meeting requirements of environment and safety. Individuals receiving Senior PSR services in a nursing home who are also Medicaid beneficiaries must also be authorized through the Preadmission Screening and Resident Review (PAASRR) Rules.

Referral/Admission to the program: Referrals may be made by a variety of sources including other CCS programs, community social service agencies, churches, nursing homes, personal care homes, law enforcement, medical personnel/services, or any interested party. A referral will be made to the Senior PSR Program Manager who will determine the person's eligibility through an interview with the person and their family (if applicable) and any available assessments. If the person is already a receiving services at CCS, the Program Manager will review information in the medical record. The Achenbach System of Empirically Based Assessment (ASEBA), specifically the Older Adult Behavior Checklist for those persons recommended for Senior PSR will be completed.

Eligibility: Eligibility criteria include that the person is fifty (50) years of age or older and has an eligible psychiatric disorder based on the current edition of the Diagnostic and Statistical Manual. The person must further be classified as having a serious mental illness as defined by DMH and exhibit symptoms of sufficient severity to cause

significant functional impairment in basic living skills, instrumental skills, or social skills, as documented by an assessment instrument/approach approved by DMH. Persons accepted for the program shall follow standard CCS' intake procedures, including the completion of an intake/initial assessment if not previously completed. Senior PSR services must be reflected on the Individual Service Plan and a prior authorization from the Division of Medicaid, or its designee, must be obtained for people who are also Medicaid beneficiaries. Persons determined ineligible for services will be referred (with permission and appropriate consents if the individual currently receives services from CCS) to programs which may be able to address the person's needs. Follow-up will be documented and kept on file at the program site.

Schedule of activities: Each Senior PSR program must have a written schedule of daily activities, available for review, which includes group therapy, socialization activities, activities of daily living, and recreational activities. Activities and physical surrounds must be age appropriate. A monthly calendar will be developed each month to identify planned activities for the upcoming month. The calendar will include daily program activities, community outings, and educational activities.

Program Activities: Psychoeducation will be a vital part of the program. Topics will include, but are not limited, to health, nutrition, recognizing and dealing with depression. Other education topics will include home safety, physical fitness/exercise, and computer use. Group and individual activities will encourage and applaud the expression of memories/stories in order to provide enhanced self-esteem and neural stimulation. People will be afforded the opportunity to participate in a wide range of creative activities including needlework, art, music, flower arrangement, gardening, etc. Such activities enhance self-esteem and lead to the enrichment of the person's leisure time. The Program Manager shall ensure that the program offers a wide range of recreational activities, both at the program site and in community settings in order to enhance physical activity, socialization, and use of leisure time; thus incorporating activities designed to rehabilitate and enhance physical coordination and meaningful leisure time activities.

Mississippi DMH Operational Standards addressed: Rule 24.2

Section: Adult Mental Health
Policy: Supported Employment Program
Policy No.: AMH 06
Effective: 1/1/2015
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to implement a supported employment program to individuals with severe and persistent mental illness that have a desire to work.

PURPOSE: The purpose is to provide supported employment to persons with severe and persistent mental illness that have a desire to work in an effort to assist individuals in achieving goals and maintaining recovery. The goal is to assist people with severe and persistent mental illness to find and maintain employment in a competitive job market. The ultimate goal of the program is to assist the person in incorporating daily activities that foster independence, self-sufficiency, and recovery.

PROCEDURE:
General Information/Eligibility: The Supported Employment (SE) program will be for people that reside with the 7 counties covered CCS. People appropriate for participation in the SE program include people with severe and persistent mental illness, as well as, people who have co-occurring issues (MH/SUD) whose illness seriously impacts their ability to function independently and in the community. People must reside within the Region VII catchment area and have communicated a desire to work. SE services are voluntary.

Supervision: SE supervisor responsibilities include a) conducting weekly SE supervision to review cases and identify new strategies to help individuals in their work lives, b) communicate with treatment team leaders to ensure SE services are integrated and to problem solve programmatic issues, c) attend a meeting for each mental health treatment team on a quarterly basis, d) accompany SE specialists who are new or having difficulty with job development, and e) review current client outcomes quarterly and set treatment goals to improve program performance.

Referral: Any person that determines/states employment as a goal should be referred to the Supported Employment (SE) Specialist. The SE Referral form will be completed by the referring individual and forwarded to the SE Specialist. Referrals will be accepted from service providers, community agencies, individuals, families or any other source who identifies a person with severe and persistent mental illness who communicates a desire to work, and meets eligibility requirements. Upon referral, the SE Specialist will meet with the person referred to ensure they meet eligibility requirements and to gather their desires and preferences regarding employment so services can be tailored to each person. The SE Specialist shall make contact within 7 days of referral.

Staffing: The Supported Employment (SE) program will consist of at least one (1) fulltime Supported Employment (SE) Specialist who has a minimum of a Bachelor's degree. SE Specialists will have no more than twenty (20) individuals on a caseload and will function as a fully integrated member of the treatment team which will be reflected as

such in the medical record. The SE Specialist(s) will meet on a weekly basis with the designated SE supervisor to discuss, problem-solve, and brainstorm on issues related to the SE program. This will also be a time to identify additional/ongoing training needs and discuss specific cases. The SE Specialist serves as a member of the mental health treatment team for people on his/her caseload and will attend meetings as scheduled. The SE Specialist will encourage team members to assess possibilities for people that have a desire to work to be referred to the SE program. The Individual Service Plan will be reviewed with the multi-disciplinary team to ensure that employment is identified as a goal on the ISP. If it is determined that employment is not addressed on the plan of care, a modification will be done to include this area. The office of the SE Specialist will be in close proximity to mental health team members in an effort to enhance collaboration and support for the SE program.

Responsibilities of the SE Specialist include, but are not limited to:

- Distributes information and communicates with potential referral sources about the supported employment program
- Develops a plan for community awareness and support of employment services/activities
- Develops relationships with local community providers for possible employment opportunities
- Advocates for employment opportunities for individuals with mental illness/disabilities
- Accepts/coordinates referrals to the SE program
- Screens people to ensure eligibility requirements are met
- Obtains interests, desires, and goals regarding people's desire to work
- Identifies integrated, competitive jobs that meet the interests, desires, and goals of the person
- Provides support services to increase independence and community integration for people enrolled in the SE program
- Identifies and establishes goals directed toward improved functioning, with emphasis placed on the preferences of the individual, in the following areas:
    - independent functioning and self-sufficiency
    - management of symptoms related to his/her mental illness
    - obtain and sustain fulfilling employment opportunities
- Provides on-going support after successful job attainment, while focusing on helping the person function as independently as possible
- Continues to provide support to assist in the process of recovery and promote permanent employment
- Participates as a member of the multi-disciplinary team for people enrolled in the program

Services: Each SE Specialist carries out all phases of vocational services including engagement, assessment, job placement, and follow-up. Services will be mobile and build on the person's desire/motivation to work. Once referred and determined eligible (an SMI adult with a desire to work) the SE Specialist will conduct job discovery with the person. During this process, the SE Specialist will work with the person to evaluate their choices regarding what is revealed to the employer about having a disability and how to communicate any need for reasonable accommodations. The initial employment

assessment and the first face-to-face employer contact must occur within one month of being in the SE program. In addition to making contacts with employers, the SE Specialist will meet with the treatment team and family members during this first month of program enrollment in an effort to develop on-going support as the person pursues employment goals. Employer contacts are based on personal job preferences and needs, rather than available jobs. SE Specialists must assist people in obtaining different types of jobs and in different settings based on the person's preferences and wants. Competitive job options that are permanent, rather than temp/time-limited status, is the goal.

The goal of the SE program is to find competitive employment based on the persons desires, preferences, and goals as quickly as possible. However, if a job meeting the person's desires is not identified within 8 (weeks) of enrollment into the SE program, the SE Specialist will collaborate with Vocational Rehabilitation and access the Linking Innovative Networks of Community Services (LINCS) program. As reflected in the LINCS program brochure, "LINCS joins client abilities with employer opportunities." A cooperative agreement is established with local employers to allow individuals to "tryout" a job and see if it meets their wants, desires, and preferences.

Service delivery: SE Specialists will make at least 6 face-to-face employer contacts per week. A tracking form will be utilized to document employer contacts and reviewed by the SE supervisor weekly. Making contact with the same employer, with or without the presence of the person, counts as an employer contact since these contacts will assist in building relationships with employers, educate the employer about the benefits of the SE program, and give an opportunity for the SE Specialist to convey the strengths that are a good match for the employer. SE Specialists must have face-to-face contact with the person 1 week prior to starting a job and within 3 days after starting a job. Subsequently, the SE Specialist will meet with the person weekly for the first month and at least monthly for a year or more as desired by the person. Job supports can be decreased following steady employment. SE Specialists shall spend 70% or more of their time in the community.

Vocational assessment: A vocational assessment and profile will be completed and updated as needed for each person in the SE program. The profile includes, but is not limited to, preferences, experiences/prior work history, skills, current adjustments, strengths, personal contacts, and other relevant background information. The profile is used to identify job types and work environments. Completion of the vocational profile can occur over 2-3 sessions and is updated with each new job experience.

Work Incentives Planning: The SE Specialist also offers assistance in obtaining comprehensive, individualized work incentives planning by a specialty trained work incentives planner. The SE Specialist must also facilitate access to planners when people need to make decisions about changes in work hours and pay. A major reason that people with disabilities do not pursue employment is their fear of losing important benefits that they receive. For this reason, benefits counseling is an important aspect of the SE program. Benefits counseling should be provided prior to work placement, once a person acquires employment, and when changes occur in their work status.

On-going support: Support will be provided to the person to help ensure that employment is maintained. Supports are individualized and ongoing and can include helping the person move on to more preferable jobs or helping people with school or certified training programs. Employer support can also be provided (i.e., educational information, job accommodations) at the individual's request. Services are continued unless the person requests services be terminated. Nevertheless, the SE Specialist is aware that their role is to help consumers become as independent as possible while being available to provide support when needed.

Engagement/Outreach: The following assertive engagement and outreach strategies are used:

- Service termination is not based on missed appointment or fixed time limits
- Systematic documentation of outreach attempts will be maintained
- Engagement/outreach shall be made by all team members
- Multiple home/community visits will be performed
- Coordinated visits by employment specialist with team member(s)
- Engage with family and identified support system (if applicable)

Business Advisory Council: A business advisory council will be established and meet quarterly. The use of zoom meetings will also be incorporated if needed to promote participation. Individuals will include representatives from Vocational Rehabilitation, Social Security Administration, Division of Medicaid, community business leaders, SE program personnel, and family members/support systems. The Business Advisory Council will be utilized to develop support for the SE program, assist in generating referrals for the SE program, increase program awareness in the community, and provide support/advise the SE program regarding implementation and sustainability. The committee will meet at least quarterly for programs that have not reached high fidelity and a minimum every six months for the programs that have received high fidelity. The SE Specialist(s) will meet with the local vocational rehabilitation agency (ies) in his/her assigned catchment area on a bi-monthly basis to collaborate about supported employment services, identify/address training needs, discuss/obtain resources, and work together on job placement and support.

Local Employer Inventory (LEI): Each program will maintain an active LEI for Region 7 which will include the name, location, and type of business, its mission and workforce objective, name of personnel director and hiring practices, and any other notes of interest.

Principles of Supported Employment:

1. People are not excluded from the Supported Employment (SE) program due to their mental illness, substance use, or past work history. Eligibility is based on individual choice. The philosophy is that all persons with a disability can work in a competitive work setting. People are "ready" to work when they communicate a desire to work.
2. People with severe and persistent mental illness have the capability to work in a competitive work environment. The goal of the program is employment in a competitive setting. People with severe and persistent mental illness working in

a competitive setting helps to reduce the stigma associated with mental illness. Self-esteem and confidence improves when the individual can work alongside others who do not have a disability, they see that their work is valued, and they realize a sense of satisfaction as they contribute to society.

3. People's desires, preferences, and strengths are matched with the job. A person's preference plays a crucial role in the type of job sought. People who obtain work in their desired area of interest report higher level of satisfaction with their job which leads to fulfilling, longer term employment.
4. Utilization of a rapid job search process. Using a rapid job search process builds on the person's motivation and desire to work. This approach communicates to the person that their desire to work is taken seriously and builds on his/her motivation to work. Allows for multiple jobs to be identified/researched before selection. Prior to searching for jobs that meet desired goals/interests, a vocational profile is developed which outlines a review of the persons prior work history, his/her preferences for certain types of work, and other relevant background information.
5. Provides on-going support, even after successful job attainment. Severe and persistent mental illness is episodic so often times, people need a long-term commitment during their recovery journey. Services are only terminated at the request of the person. The support provided over a period of time may decrease as people learn/are able to meet their own needs for success at the workplace. Ultimately, the SE Specialist assists the person in being able to function independently, while available for support when needed.
6. The SE program is closely integrated with the mental health treatment team. Coordination of supported employment with other mental health treatment ensures that vocational goals are acknowledged by all team members. Provides an avenue for discussion of clinical issues that may impact success in the work environment. Allows all team members to have input into assisting the person achieve his/her goals.
7. Personalized benefits counseling is an important component of the SE program to ensure that people receive accurate information about how employment may or may not affect their benefits. These services will be accessed by working with local Social Security Administration (SSA) benefit counselors who will be utilized to provide information based on a person's particular set of circumstances, as well as, Certified Work Incentive Coordinators (CWIC), employed through Vocational Rehabilitation, and trained by the SSA, who will be utilized to educate people who receive disability income through Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) about benefits and the effect of work on those benefits.

Program Evaluation: The SE program will incorporate a quality assurance system to include process measures to assess fidelity to the model, as well as, outcome measures to determine program results. The benefits of incorporating a quality assurance system include, identification of strengths and weaknesses, development of plans for improving program, increasing the likelihood that people will reach their recovery goals, and delivering services both efficiently and effectively. An internal review will be conducted at least every six months through the SE Fidelity Scale or until achieving high fidelity and at least yearly thereafter by the DMH Fidelity Review Team. Results should be used to improve SE implementation and sustainability. Programs will adhere to Data and

Record Keeping Requirements for Good IPS Fidelity in accordance with established guidelines.

Feedback from families and people enrolled in the SE program is essential in determining ways to improve the program, as well as, assessing outcomes. As recommended in the SE Toolkit, the following surveys/resources will be utilized:

a. The Mental Health Statistics Improvement Program Consumer Satisfaction Survey
b. A recovery measurement instrument as described in Measuring the Promise: A Compendium of Recovery Measures, Volume II

Results of assessment will be shared at all levels of the SE program. This will include sharing information with the Business Advisory Council, SE Specialists, treatment team members, families and people enrolled in the program.

Culturally Competent Services: Effectiveness of evidenced based practices are enhanced when provided services are culturally competent. Cultural competence refers to the ability to meet the needs of individuals from different backgrounds and cultures. Services must be tailored to the needs of the people participating in the program. When this is done, access to care is improved, trusting relationships are established, and people are more engaged in services. In an effort to ensure services are culturally competent, the following steps will take place:

- Conduct cultural competence assessment – The Cultural Competency Assessment Scale (CCAS) will be utilized to assess CCS level of cultural competence.
- Cultural competency training will be provided to all staff associated with the SE program (see Training Plan).
- Data will be collected to examine disparities in services.

Training Plan: The material included in the Multimedia section of the Evidence-based practices KIT – Supported Employment will be utilized to provide information/education about Supported Employment to the following:

1. People that meet eligibility requirements, families, service providers, community agencies, employers, and stakeholders/advisory council members.
2. Intensive training for supported employment specialist will include completion of the 4 session training outlined in Supported Employment – EBP Kit: Training Frontline Staff. Relias Learning coursework will be completed in the following 3 areas: 1) Supported Employment, 2) Cultural Diversity/Competency, and 3) Recovery. If available, staff employed with the SE program will visit an existing, high-fidelity SE program. Regular trainings will be provided to educate SE Specialist(s) on benefits and work incentives. The SSA will be contacted/used to access training resources, education, and consultation. On-line resources will also be utilized such as disabilityinfo.gov, ssa.gov, and samhsa.gov
3. Basic training on supported employment will be provided to all service providers. Training will include, but not be limited to, a) an introductory Power Point Presentation and video used to educate service providers about the SE program, b) brochures about the program will be distributed and available for review, and c) information will be published in the agency newsletter.

Mississippi DMH Operational Standards addressed: Rule 24.4, 24.5

Section: Adult Mental Health
Policy: Adult Making a Plan (AMAP) Teams
Policy No.: AMH 07
Effective: 04/22/2014
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to utilize AMAP Teams to address the needs of adults with serious mental illness or co-occurring disorders who have frequent/multiple placements in inpatient psychiatric services.

PURPOSE: Reduce the number of psychiatric hospitalizations and enable people to live in a less restrictive environment.

PROCEDURE: Adult Making a Plan (AMAP) Teams address the needs of adults, eighteen (18) years and above, with serious mental illness or co-occurring disorders (SMI/DD or SMI/A&D) who have frequent/multiple placements in inpatient psychiatric services which could possibly be prevented with the coordinated efforts of multiple agencies and services.

AMAP Coordinator: CCS identifies an individual with at least a Bachelor's degree to serve at the Coordinator of the AMAP team.

Team members: The following team members are recommended and should be present and their presence documented at each AMAP Team meeting (if applicable):

1. The person being referred to the AMAP Team, family member, and/or advocate representing the individual
2. The person's therapist, community support specialist, or other CCS staff member who has detailed knowledge of the person
3. A representative of the Chancery Clerk's Office or the Chancery Court
4. A representative of the sheriff's department of the county in which the person resides and/or a representative of the police department in the city of residence
5. Staff member(s) from the regional behavioral health program or crisis stabilization unit that has had frequent contact with the person

CCS maintains a current written interagency agreement with agencies participating in the AMAP Team.

General: The overall goal of the AMAP Team is to develop a new and different intervention for the person in order for them to have a greater success of being maintained in a community setting. Previous treatment, modified future service plan and completion of a Crisis Support Plan must be documented on the Case Summary Form. The AMAP Team Monthly Reporting form and the AMAP Team Case Summary forms must be submitted to DMH by the AMAP Team Coordinator with each cash reimbursement request (if funding is available) and copies must be maintained on-site with the AMAP Team Coordinator. For anyone who has been previously referred to the local AMAP Team

to be placed at/committed to an inpatient psychiatric facility, the local AMAP Team must attempt to develop a less restrictive alternative in the community.
Outreach: It is the responsibility of the AMAP Team Coordinator to provide information about the AMAP Team to all Chancery Clerks and Sherriff's Departments in the CCS catchment area. In addition, the coordinator shall provide information about his/her AMAP Team (i.e., contact person, meeting schedule, etc.) to each state operated behavioral health facility, CMH certified Crisis Stabilization Unit, and the DMH Office of Consumer Support.

Mississippi DMH Operational Standards addressed: Rule 33.1, 33.2

Section: Adult Mental Health
Policy: Intensive Community Outreach and Recovery Team (I-CORT)
Policy No.: AMH 08
Effective: 08/28/2019
Revised/Approved: 6/22/2021

POLICY: It is the policy of Community Counseling Services (CCS) to provide intensive community-based rehabilitation and outreach services to people with severe and persistent mental illness who have a history of multiple hospitalizations, extensive use of Mobile Crisis Response Team services, significant difficulty meeting basic survival needs, or have not been successful in meeting goals with traditional office-based outpatient services.

PURPOSE: The purpose of this program is to provide intensive community-based services in the person's natural setting, in addition to, providing individualized interventions to meet defined recovery and resiliency goals. The ultimate goal is to assist in the development of stability and independence so the person can remain in the community as independently as possible, avoiding placement in state-operated behavioral health service locations.

PROCEDURE:
General Information: The Intensive Community Outreach and Recovery Team (I-CORT) is a recovery and resiliency oriented, intensive, community based rehabilitation and outreach service for adults with a severe and persistent mental illness. It is a team oriented approach to mental health rehabilitation intervention and supports necessary to assist people in achieving and maintaining rehabilitative, resiliency and recovery goals. Services are delivered face-to-face with the person and their family/significant other as appropriate and will be provided in the person's natural/community setting 75%-85% of the time.

Eligibility Criteria: To be eligible for services, the person must have a severe and persistent mental illness as listed in the most current edition of the Diagnostic and Statistical Manual (DSM). Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. The person's diagnosis must severely impact their ability to function in a community setting and must demonstrate significant functional impairment in at least one of the following areas: a) basic daily living tasks required for functioning in the community, b) maintaining consistent employment or being able to carry out needed homemaker roles, or c) maintaining a safe living situation.

The person must present with one or more of the following problems, which are indicators of high service needs:

1. High use of acute psychiatric hospitals (e.g., two or more admissions per year) or psychiatric emergency services (extensive use of Mobile Crisis Response Team services).

2. Intractable (i.e., persistent or very recurrent) severe major symptoms (e.g., affective, psychotic, suicidal).
3. Coexisting substance abuse disorder of significant duration (e.g., greater than 6 months).
4. High risk or recent history of criminal justice involvement (e.g., arrest, incarceration) due to behavioral problems attributed to the person's mental illness.
5. Significant difficulty meeting basic survival needs, residing in substandard housing, homelessness, or imminent risk of becoming homeless.
6. Residing in an inpatient or supervised community residence, but clinically assessed to be able to live in a more independent living situation if intensive services are provided, or requiring a residential or institutional placement it more intensive services are not available.
7. Difficulty effectively utilizing traditional office-based outpatient services (office- based individual and/or group therapy, psychosocial rehabilitation, and medication monitoring.)

Exclusionary Criteria: People who a) are under the age of 18, b) have no prior history of psychiatric hospitalization or use of Crisis Services, b) are able to maintain clinic appointments/goals can be met with traditional outpatient services, c) have a primary diagnosis of a substance abuse disorder, mental retardation or primary personality disorders, and/or d) have a chronic history of violence are not the intended group for this service.

Discharge Criteria: Discharges from I-CORT occurs when the treatment team, inclusive of the person, mutually agrees to the termination of services. Reasons include a) successfully reaching established goals, b) successfully demonstrates the ability to function in all major role areas without ongoing assistance and/or significant relapse, c) moves outside the service area, d) declines/refuses services despite the team's best effort to develop an acceptable ISP with the person.

Staffing Requirements: A multi-disciplinary team will be used to support the individuals enrolled in the I-CORT program. Team members will have the ability to provide a variety of functions and must demonstrate a willingness to be flextime in their duties. Services provided by the multi-disciplinary team will include peer support services, therapy, medication administration/monitoring, general health care monitoring/treatment, supportive counseling, social/hygiene skills training, recovery/resiliency support, symptom management, budgeting skills, and leisure time activities. The team shall provide support to individuals, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to reach goals as identified on the ISP and Recovery Support Plan. The team will be made up of a full-time Master's Level Mental Health Therapist (CMHT or independent license), a full-time equivalent Certified Peer Support Specialist (CPSS) and a full-time Registered Nurse (RN), a full-time equivalent Certified Community Support Specialist (CCSS), a part-time clerical staff.

Staff Training: Staff members assigned to the I-CORT team will have received training in accordance to the staff training plan. In addition, members will receive training on

Applied Suicide Intervention Skills Training (ASIST), Mental Health First Aid (MHFA), DLA-20, DMH documentation requirements, supported employment services, Crisis Prevention Intervention (CPI), Pre-evaluation screening, CHOICE, and Peer Support Specialist and Supervisor Training (as applicable).

Service Requirements: The team will serve a maximum of 45 people with a ratio of no more than 1:15 for each team member. Services are provided based on individual need, but no less than two times/two hours per week. Each team member must provide services as often as therapeutically necessary. Services are available 24 hours per day/7 days per week. After-hours crisis support will be provided by the CCS Emergency On-Call rotation and M-CeRT team. Response to a crisis by an individual enrolled in I-CORT will be by an I-CORT team member. Each person will receive services from a psychiatrist/PMHNP at a minimum of one time every 30 days. These services can be provided in the community or in an office setting. The I-CORT team will facilitate and/or provide transportation (if necessary).

Activities/Interventions: Interventions will be individualized for each person enrolled in the I-CORT program. These may consist of, but are not limited to, the following: a) promotion of the individual's active participation in decision making and self-advocacy, b) identification of strengths which may assist in reaching recovery/resiliency goals, c) identification of barriers to recovery/resiliency and how to overcome them, d) development of strategies and supportive interventions for achieving and maintaining placement in the least restrictive setting, e) identification, development and maximizing natural support systems, f) identification of risk factors related to mental health and/or co-occurring disorders relapse and development of strategies to prevent relapse, g) development of Individual, Recovery, and Crisis Support Plans, and h) development of daily living and functional living skills which allow the person to succeed within the home and community setting.

Team Planning/Communication/Documentation: Daily organizational meetings will be held at a regularly scheduled time. Ideally, all team members will be physically present at the same location; however, when necessary, telehealth can be utilized to ensure all members are involved. A written daily log will be maintained which includes the roster of people served by the program and documentation of any treatment/service contacts that have occurred in the last 24 hours. A review of the written daily log will be used to update all team members on the contacts that occurred the day prior and to review the schedule for the day. A weekly individual schedule will be maintained for each person enrolled in the program. These will be kept on file for review as needed. There will be a daily staff assignment based on the weekly individual schedule for people enrolled in the program. This daily staff assignment will also include collateral contacts needing to be made, medical record review/documentation, treatment planning/development, and other activities performed by staff. The daily organizational meeting will allow for staff assignments to be reviewed and service activities assigned to ensure that all tasks are completed. The I-CORT team will adhered to all DMH documentation and reporting requirements.

Process/Outcome Measures: Several tools will be utilized to determine if goals and/or objectives are being met. This will include a) improved symptoms and social functioning as indicated on the DLA-20, b) increased consumer and family satisfaction with services,

c) an improved or satisfaction with quality of life as reflected by the Recovery Assessment Scale, d) a reduction in admissions to state-operated behavioral-health facilities by 25% from people in the I-CORT program, and e) an increase in the utilization of alternative placement/treatment options for people who have had multiple hospitalizations and do not respond to traditional treatment(s) by 25%.

Monthly Reporting: The I-CORT Team will submit the Monthly Data Report by the 15th of each month for the prior month's activities.

Outreach: Outreach to local community stakeholders and referral services (Doctors, CSU's, hospitals, etc.) at least once per quarter and documented on the monthly data report.

Mississippi DMH Operational Standards addressed: Rule 32.9, 33.10, 32.12, 32.13