Section: Children's Mental Health
Policy:
Policy No.: CMH 01
Effective:
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Reserved for future use

Section:	Children's Mental Health
Policy:	Resolving Conflicts between Minors and Family/Guardian Concerning Care during Treatment
Policy No:	CMH 02
Effective:	01/01/1995
Revised/Approved:	03/22/2011

POLICY: Due to the fact that conflicts are known to have arisen in the past regarding assessment, treatment (including use of medication) and referral in the best interest of minor children, it is the policy of Community Counseling Services to utilize the following procedures in resolution of difficulties or conflicts occurring between minor program participants and family/guardian during the treatment process.

PURPOSE: To assure a method of resolving difficulties or conflicts that may arise between a minor program participant and his/her family/guardian during the treatment process and to outline the necessary documentation required to insure that every effort has been made to resolve the conflict

PROCEDURE: When conflicts arise, a staff member involved in the treatment of the individual receiving services and his/her parent(s)/legal guardian will address conflict situations as they occur. The staff member should be someone who is capable of approaching involved parties and has the skills to assist in resolving the conflict. If necessary, a staff member may refer to additional members of the treatment team for assistance, such as the therapist or community support specialist assigned to the case and/or the County Administrator/Supervisor. If additional assistance is sought from members of the treatment team, the identified team member will work with the individual receiving services and his/her parent(s)/legal guardian in attempts to resolve the conflict.

If the conflict cannot be resolved at levels 1 and 2 above, an attempt will be made to schedule a treatment team meeting. Present for the meeting shall be members of the treatment team, the individual receiving services, and the parent(s)/legal guardian. If the individual receiving services and his/her parent(s)/legal guardian is not available to attend the treatment team meeting, a family session will be scheduled in the home to address the identified conflict and share the recommendations established at the treatment team meeting. This visit will be scheduled as quickly as possible should a serious conflict occur. In some instances, it will be necessary for more than one member of the treatment team to be present for the home visit.

If the conflict has to do with the use of medication or assessments, the psychiatrist or his/her designee will attempt to resolve the conflict by meeting with the family and the individual receiving services, utilizing consultative, educational and conflict resolution techniques. If the conflict has to do with the treatment recommendations or referral of the individual receiving services to a more intensive treatment modality, a meeting with the family, individual receiving services, County Administrator/Supervisor and therapist may be scheduled to review the discuss the areas of concern and make recommendations.

If the conflict remains present after the above interventions have been utilized, other appropriate professional staff members may be utilized to assist the family and individual receiving services in resolving their conflict. A course of treatment that is based on the views of all involved parties, addresses the individuals/families concerns, and the best interests of the child/youth will be decided. This will be communicated to the individual receiving services, his/her family and the therapist. All recommendations will be documented in the medical record of the individual receiving services. The resolution of the conflict or the course of action taken if resolution of the conflict did not occur will become a part of the permanent record of the individual receiving services.

Section: Child/Youth Mental Health
Policy: Family Support and Education for Children and Youth
Policy No.: CMH 03
Effective: 09/22/1998
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services to offer and implement family support and education services to families of children diagnosed with a serious emotional disturbance.

PURPOSE: To increase the number and quality of self-help and mutual support efforts for individuals receiving services and their families, based on the view that individuals with similar circumstances have the capacity to understand and assist each other and that the support of other concerned individuals is a great asset in helping to cope with difficulties

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

It shall be the responsibility of each County Administrator/Supervisor to coordinate family education and family support services in the county for which he/she is responsible. Identified individuals within the organization have documented training completed in family education and support (i.e., Mental Health First Aid, peer support training) for families of children/youth with severe emotional disorders and are available to provide education and support upon request. It is the responsibility of each County Administrator/Supervisor to develop and implement a plan for outreach and education that at a minimum, addressed the following:

- A description of individuals targeted to receive Family Support and Education Services
- Specific strategies to be used for outreach to the target population for Family Support and Education Services
- A description of qualifications and specialized training required for family support and education providers
- A description of the service components of Family Support and Education Services

Each County Administrator/Supervisor shall ensure that a variety of appropriate family education activities for families of children/youth with severe emotional disorders is made available. Possible methods of delivering those services to an individual family or a group of families include, but are not limited to, the distribution of pamphlets and brochures, conducting workshops and presentations, and/or other social activities and meetings. Workshops and presentations providing educational activities must be documented including the presentation topic, brief description of information provided, target audience, date, number of participants, and name of presenter/qualifications. It is the responsibility of each County Administrator/

Supervisor, in cooperation with the Department of Human Resources, to ensure that all individuals providing family support and education services are qualified and have applicable experience/knowledge in the topic(s) being presented.

Presentations/workshops must address one or more of the following or other DMH pre-approved topics:

- Identified methods and approaches commonly used to identify children/youth with behavioral, conduct or emotional disorders
- Development of a family action plan
- Prevalent treatment modalities
- Common medications
- Child development
- Problem-solving
- Effective communication
- Identifying and utilizing community resources
- Parent/professional collaboration
- Overview of a collaborative service network
- Consultation and education
- Pre-evaluation screening for civil commitment for ages fourteen (14) and up

The County Administrator/Supervisor shall also ensure that appropriate outreach efforts are conducted routinely. Outreach shall include, but is not limited to, regular outreach efforts with area professionals, local community agencies, local area media outlets, and opportunities for public service presentations. Additional information regarding community relations and outreach can be found in the Community Relations (CR) section of CCS' Policy and Procedure manual. Specifically, policy CR 02 identifies CCS' expectation to provide consultation, education, and community awareness within the Region VII catchment area and that all staff members have a responsibility to provide education/accurate information in their communities about mental health issues.

Mississippi Operational Standards addressed: 38.1

Section: Child/Youth Mental Health
Policy: Children's Day Treatment Programs
Magnolia and Back on Track
Policy No.: CMH 04
Effective: 03/14/1997
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services to offer therapeutic day treatment to children, ages five (5) through twelve (12) and middle and junior high school students who exhibit emotional and/or behavioral problems, and for whom the service is a medical necessity.

PURPOSE: To provide an alternative to and diversion from residential placement or acute hospitalization and to aid individuals making the transition from such services to maintenance within the community

PROCEDURE: Day Treatment Services are the most intensive outpatient services available to children/youth with SED. The services provide an alternative to residential treatment or acute psychiatric hospitalization or serve as a transition from these services. Day Treatment Services are a behavioral intervention and strengths-based program, provided in the context of a therapeutic milieu, which provides primarily school aged children/adolescents with serious emotional disturbances, the intensity of treatment necessary to enable them to live in the community. Day Treatment Services are based on behavior management principle and include, at a minimum, positive feedback, self-esteem building and social skills training. Additional components are determined by the needs of the participants at a particular site and may include skills training in the areas of impulse control, anger management, problem solving, and/or conflict resolution. At a minimum, one (1) Children's Day Treatment Program is offered to each school district in the region served by each CMHC. For school districts that do not offer day treatment, documentation shall be maintained by each County Administrator/Supervisor reflecting attempts made to offer day treatment services for school districts in their county.

Eligibility: To be eligible for day treatment services, children/youth must have a serious emotional disturbance as defined under the SMI/SED determination section in policy GS 01 or Autism/Asperger's disorder and justification reflecting the need for Day Treatment Services. Justification must include documentation of the intensity and duration of problems as part of the initial assessment or as part of a post-intake case staffing and at least annually thereafter. Documentation must also include the identification of at least three (3) specific behavioral criteria as set forth by DMH whose severity would prevent treatment in a less intense environment. Children must be between the ages of three and twenty-one (3 – 21) to be considered for enrollment in Day Treatment Services. In addition, Day Treatment 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 individuals receiving day treatment services who are also Medicaid beneficiaries.

General Guidelines: Each individual Day Treatment Program operates at a minimum of two (2) hours per day, two (2) days per week up to a maximum of five (5) hours per

day, five (5) days per week. Each child/youth enrolled in Day Treatment Services receives the service a minimum of four (4) hours per week. Only one (1) Day Treatment Services program is allowed per room during the same time period with a minimum of twenty (20) square feet of usable space per individual. Furnishings, equipment, square footage and other aspects of the Day Treatment Program environment must be age-appropriate, developmentally appropriate, and therapeutic in nature. Each Day Treatment Program operates with a minimum of four (4) and a maximum of ten (10) children/youth and each program must operate under a separate DMH Certificate of Operation. In order to participate in the Day Treatment program, a child or youth must be on the permanent roster for the program. No child/youth shall participate on an intermittent basis. A Day Treatment roll/roster cannot exceed ten (10) children/youth per program. For Day Treatment Programs developed and designed to serve primarily children/youth with a diagnosis of Autism or Asperger's shall not include more than four (4) children/youth with a diagnosis of Autism/Asperger's. Day Treatment Services are intended to operate year-round and cannot be designed to operate solely during the summer months. To ensure each child's confidentiality, no children other than those enrolled in Day Treatment Services can be present in the room during the time Day Treatment Services are being provided.

Staffing: The ratio of staff to children/youth receiving services in each Day Treatment Program is maintained at a minimum ratio of two (2) on-site persons for a minimum of four (4) up to a maximum of ten (10) children/youth per program. Each program is led by a Therapist and a Day Treatment Assistant serves as the second staff member. All therapists providing day treatment services must have at a minimum a Master's degree in a mental health or related field and a professional license **or** hold Department of Mental Health Certification. The therapist assigned is responsible for providing individual, family and group therapy to the children enrolled in his/her Day Treatment program, as well as, providing follow-up/aftercare for those individuals who have graduated from the program. In addition, they are responsible for working directly with the children to assist in the supervision and maintenance of each individual's treatment goals. The therapist participates in clinical staffing for the individuals in the program for which he/she serves as the primary clinical staff member. Responsibilities of the Day Treatment Therapist and Assistant include, but are not limited to, providing day treatment, daily documentation, conducting home and school visits, conducting follow-up for program participants, maintaining daily program planning, determination strengths, objectives and recovery goals for each child in the program, working as a team member with all other staff members, coordination and maintenance of the intake and referral system, and maintenance of the aftercare phase of the program.

Another critical component of the day treatment program is community support services. The community support specialist, who must hold at least a Bachelor's degree in a mental-health related field, is responsible for assessing what other services are needed or desired and for assisting the child in obtaining those services. The community support specialist will also follow-up with program participants and assist in the maintenance of their recovery goals. The community support specialist is an integral part of the treatment team. He/she serves as an extension and liaison of the program to the home and school, as well as to various community services utilized by program participants.

Staff training/development requirements are delineated in Community Counseling Services Policy: HR 34 Training of Staff Members/Staff Development

Supervision: The County Administrator/Supervisor, holding a Master's degree and a professional license or Department of Mental Health credential will oversee the entire administration of the program, including but not limited to, budget and finances, hiring and training of new employees, supervision of staff members in their capacity to provide services, coordinating and implementing new programs, and evaluation of the effectiveness of the Magnolia programs. County Administrator/Supervisor or his/her designee has the responsibility to monitor and evaluate Day Treatment Services in his/her county. Supervision/monitoring is provided at least one continuous hour per month. This includes participation in clinical staffing and/or Treatment Plan Reviews for the individuals in the program(s) that he/she supervises. In addition, the County Administrator/Supervisor or his/her designee provides at least thirty (30) continuous minutes of direct observation to each individual Day Treatment program at least quarterly. Documentation of the supervision/observation is maintained for review.

Interruption in service/summer schedule: DMH Division of Certification must be notified immediately of any interruption of service with an individual Day Treatment program extending over thirty (30) days. If operation has been interrupted for sixty (60) calendar days, the DMH Certificate of Operation for that individual program must be returned to the DMH Division of Certification. Day Treatment Service programs that are unable to provide services during a school's summer vacation will be allowed to hold that individual program's Certificate of Operation until it can be reopened the following school year. If the program has not reopened within sixty (60) calendar days from the first day of the school year, the Certificate of Operation must be returned to the DMH Division of Certification. The County Administrator/Supervisor shall ensure that mental health services are offered to the child/youth during the summer and/or vacation time if his/her day treatment program is temporarily not operational. These services may include day treatment services, if needed, provided at other sites, maintaining program capacity requirements. In addition, therapy and community support services will be made available. Documentation must be maintained in the individual's case record that the availability of such services was explained and services were offered to the parent(s)/legal representative(s). If the parent(s)/legal guardian(s) refuse the offer of such services, this shall be documented in the case record.

Day Treatment programs operated at school: Individual Day Treatment programs operated in a school ensure that day treatment programs adhere to all DMH Operational Standards for MH/IDD/SUD Community Service Providers for this service. For programs located in a school, the mental health provider is responsible for ensuring that the school district provides a site or facility that meets all DMH Health and Safety requirements. Programs that are conducted in space that is currently accredited by the Mississippi Department of Education will be considered as meeting all Environment/Safety standards. Day Treatment Services and educational services may not be provided concurrently.

Programmatic: Each Day Treatment program is designed and conducted as a therapeutic milieu as evidenced by the use of a curriculum approved by the DMH and

includes, but is not limited to, such skill areas as functional living skills, socialization or social skills, problem-solving, conflict resolution, self-esteem improvement, anger control and impulse control. The approved curriculum is kept on site. All activities and strategies implemented are therapeutic, age appropriate, developmentally appropriate and directly related to the objectives in each child/youth's Individual Service Plan. Each Day Treatment Program has a monthly Master Schedule posted at each location to include, at a minimum, the specific skill areas being addressed each day and the specific times these skill areas are being addressed. Skill area activities shown on the Master Schedule are curriculum-specific.

Family involvement: All Day Treatment Programs include the involvement of the family or individuals acting in loco parentis as often as possible, but not less than twice per month, in order to achieve improvement that can be generalized across environments.

Transition planning: For all children/youth participating in Day Treatment Programs, there is documentation of plans for transitioning a child to a less intensive therapeutic service. This documentation is a part of each child's Individual Service Plan and/or case staffing. Transition planning shall be initiated when the child begins to receive Day Treatment Services and is documented within one (1) month of the child/youth's start date for the service.

Magnolia/Back on Track Day Treatment Programs: Children participating in Magnolia programs are ages five (5) through twelve (12), exhibit emotional and/or behavioral problems, and for whom the service is medical necessity. Adolescents participating in the Back on Track programs are junior high/middle school aged students up to age twenty one (21), exhibit emotional and/or behavioral problems, and for whom the service is medical necessity. Programs are operated at school-based sites, as well as, CMHC facilities. All are conducted in attractive, safe and sanitary environments. Treatment environments are age-appropriate, developmentally appropriate, and therapeutic in nature. Referrals are received from parents/guardians, school personnel, psychologist, pediatrician or other health care provider, CCS staff members, Department of Human Services personnel, or any other interested agency/individual.

Eligibility criteria: Children ages 5-12 who exhibit severe emotional/behavioral problems (Magnolia) and junior high/middle school aged students under (18) years of age (Back on Track) are eligible for day treatment services. The child/youth has at least one eligible diagnosable mental disorder as defined in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including Autism/Asperger's Disorder, and is classified as having a Serious Emotional Disturbance as defined by the Department of Mental Health. Other program requirements include:

- The child/youth exhibits symptoms of sufficient severity to cause significant impairment in day-to-day social, vocational, and/or educational functioning.
- The child/youth is able to exhibit adequate control over his/her behavior and is judged not to be immediately dangerous to self or others.
- The child/youth has the physical and intellectual capacity to actively participate in all aspects of the therapeutic program, as well as being cognitively able to process the relationship between behaviors and consequences (A child is not enrolled or denied placement based on an I.Q. score or type of classroom in

which the child is classified. However, the student must demonstrate the cognitive ability to comprehend the behavioral program. The treatment team may make exceptions if it is determined that the child's emotional disturbance is the limiting factor of his/her cognitive ability. The treatment team will make these and other exceptions on an individual basis.)

- The child/youth is ready for discharge from an inpatient or residential setting, but is assessed as needing daily monitoring, support and ongoing therapeutic interventions.
- Exceptions to age requirements are available to meet the needs of specific school systems and/or developmental ages of referrals.
- The child/youth has not made sufficient clinical gains within outpatient/community support services, or the severity of his/her presenting problems is such that success in only an outpatient/community support services is unlikely.
- The child/youth is at a high risk of out-of-home placement
- The child/youth is in foster care, experiencing multiple foster home placements or transitioning from foster care back into the natural home
- The child/youth is in need of a transitional experience from a more restrictive environment to a less restrictive environment

Children/youth who do not meet the eligibility criteria for the program will be referred for services for which they are eligible and appropriate to meet their needs. Day Treatment program staff members are responsible for making follow-up calls to ensure that appropriate services were accessed by the child/family. All referrals and follow-up contacts must be documented in the individual's case record.

Intake/Initial Assessment: The intake/initial assessment is designed to give all information necessary to determine whether or not the child/youth's problems are of sufficient severity/intensity and duration to merit the intensity and frequency of day treatment. Once a referral has been made, the program therapist will meet with the family, the student, and school faculty to determine appropriateness for the program. An appointment for an interview with the parent and the child/youth will be scheduled with the program therapist. If the individual is not a current Community Counseling Services recipient of services, an intake will be completed consistent with policy GS 01: Initial Assessment/Eligibility. Documentation must also include the identification of at least three (3) specific behavioral criteria as set forth by DMH whose severity would prevent treatment in a less intensive environment. After appropriate consents to release information are signed, the school will forward school records, academic achievement, school testing, and behavior checklists/reports to the day treatment staff. From this information, an assessment will be made. The treatment team will discuss the child/youth's initial interview and his/her appropriateness for day treatment. If the treatment team determines that the child/youth is appropriate for the program, he/she will be considered for immediate enrollment. Prior authorization for Day Treatment from the Division of Medicaid, or its designee, must be obtained for individuals receiving Day Treatment services who are also Medicaid beneficiaries.

Waitlist: If there are no current vacancies in the program or the child/youth is not appropriately suited for the current group dynamics, he/she will be placed on a

waiting list. While on the waiting list, the child/youth and family will be referred and linked to another therapeutic service. Those on the waiting list are admitted based on the following considerations:

- Degree of risk for out-of-home placement and removal from school
- Family support
- Length of stay on the waiting list
- Group dynamics
- Severity of problems

Justification for day treatment: A justification of the need for day treatment will be included on the Individual Service Plan. Documentation of intensity and duration will be included. If the individual is a current Community Counseling Services client, an addendum to the individual service plan will be completed with supports the need for day treatment. Justification for day treatment services and severity of presenting issues will reflect that treatment in a less intensive environment has been/or would be unsuccessful.

Program enrollment: At this time of enrollment into day treatment, the child/youth and his/her parent/guardian will be given an orientation to the program which includes a) an introduction to program rules, including the requirements for parent/guardian participation, and b) an explanation of all rights of the individual receiving services, as well as grievance procedures, including the toll-free number for the Office of Consumer Support at the Department of Mental Health.

Program dynamics: The programs operate within a therapeutic milieu to increase appropriate behaviors and decrease inappropriate behaviors. This is accomplished by teaching the child/youth that there are consequences, good and bad, based on his/her behavior and choices. The program focuses on the strengths of the child/youth to promote the opportunity for appropriate behavior. Because day treatment provides therapeutic services while maintaining the child/youth in the home, it serves to foster a better community awareness of emotional and behavioral problems and the need for development and support of these services. The therapeutic nature of the program is carefully documented in the individual service plan of each individual served. The therapeutic services that are components of Day Treatment Programs include:

- Day treatment
- Individual therapy (no less than 1 time per month)
- Group therapy
- Family therapy (no less than 2 times per month in order to achieve improvement that can be generalized across environments)
- Community Support Services

Program Goal: The goal of the Magnolia Program/Back on Track program is to help the child/adolescent become a more responsible, productive individual capable of maintaining appropriate behavior within the regular home, school and community environment.

Therapeutic components: All activities and strategies implemented are therapeutic and directly related to the individual objectives on each individual's service plan. Day treatment services are based on behavior management principles of which positive

feedback is a critical component. Skill areas addressed by the program include, but are not limited to:

- Functional living skills: personal hygiene, health and safety maintenance, daily living skills
- Social skills: responsibility, communication
- Relationship skills: interpreting events, trust building, empathy for others, conflict resolution
- Problem-solving skills
- Stress management: breathing, meditation, imagery techniques
- Self-esteem improvement
- Self-identity development: identifying strengths and weakness
- Impulse and anger control

Curriculum will be incorporated to address skill areas outlined in this policy. Curricula and evidenced based practices currently being utilized in day treatment programs operated by Community Counseling Services include, but are not limited to:

- ARISE Curriculum
- Goldstein's Skillstreaming: A Guide for Teaching Prosocial Skills
- Goldstein's The Prepare Curriculum: Teaching Prosocial Competencies
- Goldstein's and Glick's: Aggression Replacement Training
- SPARCS

Supplemental materials may be used to address particular issues that arise in the day treatment program that is not adequately addressed by the above mentioned curriculum. The Day Treatment Therapist shall ensure that schedules of day treatment activities are maintained on file for at least three (3) months which indicate that activities are related to implementation of objectives in individualized service plans of children served in the program.

Each County Administrator/Supervisor shall ensure that the Day Treatment Program(s) located in his/her county has access to a Day Treatment Manual and the Policy and Procedure for day treatment which includes, but is not limited to a) the program's purpose, goals and objectives, the population served, and the range of diagnostic categories served, b) strategies utilized in diverting children/youth from residential treatment; how the program will serve as an alternative to and/or transition from residential treatment, c) screening, selection, admission and discharge procedures, d) program policies and procedures, e) plan for intervention management and resolution of aggressive and assaultive behaviors, f) description of procedures for determining the need for and development, implementation and supervision of behavior change/management programs, and g) plan for transitioning a child/youth to a less intensive therapeutic service when deemed clinically appropriate.

First aid and safety: As indicated, all programs are conducted in safe and sanitary environments including: a) access to a first aid kit meeting DMH standards and contents, b) approved fire extinguishers and alarms/smoke detectors which show evidence of annual fire department inspection must be strategically placed, and c) in school district based programs, Community Counseling Services is responsible for ensuring that the school district provides a site or facility that meets all of DMH Health and Safety requirements. Programs that are conducted in a space that is

currently accredited by the MS Department of Education will be considered as meeting all Environment/Safety standards.

The County Administrator/Supervisor shall ensure that there is available for review documentation of an interagency agreement/MOU between the school district(s) and Community Counseling Service for each school district in which CCS provides mental health services. The agreement will include: 1) Describes in detail the respective responsibility(ies) of each entity in the provision of mental health services provided in the local school and any support services necessary for the provision of that service (such as facilities, staffing, transportation, etc.), and 2) Includes a written acknowledgment of the school district's receipt and understanding of standards applicable to the children's mental health services.

Mississippi Operational Standards addressed: Rule 26.1

Section: Child/Youth Mental Health
Policy: Making a Plan (M.A.P) Teams
Policy No.: CMH 05
Effective: 10/01/2002
Revised/Approved: 04/22/2014

POLICY: It is the policy of Community Counseling Services to participate in the Making a Plan Team (MAP) process to address the needs of children, up to age twenty-one (21) years, with serious emotional/behavioral disorders, substance use disorders or co-occurring disorders who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

PURPOSE: To ensure that children/youth receive all available essential services and that teams have a uniform core of representatives from basic community service agencies in order to benefit children with serious emotional disorders

PROCEDURE: Making a Plan (MAP) Teams address the needs of children, up to age twenty-one (21) years, with serious emotional/behavioral disorders and dually diagnosed with serious emotional/behavioral disorders and an intellectual disability or SED and alcohol/drug abuse; who require services from multiple agencies and multiple program systems, and who can be successfully diverted from inappropriate institutional placement.

It is the responsibility of the Executive Director to ensure that Community Counseling Services makes available and participates in at least two (2) standing MAP Teams in its region. The Executive Director also ensures that each MAP Team is comprised of at least one child behavioral health representative employed by Community Counseling Services who has a Bachelor's degree. In addition there shall be at least one representative from each of the following:

- Each local school district in a county served by a MAP Team
- County Family and Children's Services Division of the State Department of Human Services
- County or Regional Youth Services Division of the State Department of Human Services
- County or Regional Office of the State Department of Rehabilitation Services
- County or Regional Office of the Mississippi State Department of Health
- Parent or family member with a child who has experienced an emotional and/or behavioral disturbance
- Additional members may be added to each team, to include significant community-level stakeholders with resources that can benefit the children with serious emotional disturbance

Access: It is also the responsibility of the Executive Director to ensure that there is a written plan that describes how each county in the catchment area will develop or have access to a MAP Team. Community Counseling Services works with Making a Plan (MAP) teams in Clay, Lowndes, Noxubee, Oktibbeha, Webster, and Winston Counties. Children in Choctaw County may be served by the team in Webster County

or the team in Winston County. It is the responsibility of the County Administrator/Supervisor in those counties to ensure a current written interagency agreement will be maintained with agencies participating in the MAP Team.

Interagency agreements: Community Counseling Services maintains current written agreements with all agencies participating in its MAP teams that identify the primary functions of the team, including at a minimum:

- Review of cases of children/youth, ages up to twenty-one (21) years, when appropriate, who have a serious emotional disturbance and are at risk for inappropriate out-of-home placement due to lack of access to or availability of needed services in the home and community
- Identification of community-based services that may divert children/youth (described in #1) from out-of-home placement
- Facilitation of the provision and coordination of services across agencies/entities for the target population
- Facilitation of continuity of care for children/adolescents with serious emotional disturbance
- Facilitation of support for children/youth with serious emotional disturbance and their families

Referrals for PRTF: Before referring a child/youth to a Psychiatric Residential Treatment Facility (PRTF), Community Counseling Services must first have the local MAP Team review the situation to ensure all available resources and service options have been utilized. This does not include those children/youth that are in immediate need of acute hospitalization due to suicidal or homicidal ideations or have been referred for such service by a psychiatrist or psychiatric mental health nurse practitioner.

Mississippi Operational Standards addressed: Rule 39.1, 39.2

Section: Child/Youth Mental Health
Policy: Intensive Outpatient Psychiatric Services – Children/Youth
Policy No.: CMH 06
Effective: 06/25/2013
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services to provide Intensive Outpatient Psychiatric Services to children and youth (IOP-C/Y) with severe emotional disturbance and their families. IOP–C/Y services are designed to diffuse current crisis situations, provide family stabilization, and reduce the likelihood of recurrence.

PURPOSE: The purpose of IOP-C/Y services is to provide family stabilization through intensive outpatient psychiatric treatment to children and youth with serious emotional disturbance and their families.

PROCEDURE: The goal of IOP-C/Y services is to stabilize the living arrangement, promote reunification in the home, and prevent the utilization of out of home placement/services (i.e., psychiatric hospital, therapeutic foster care, residential treatment facility). Services are time-limited and include intensive family preservation interventions intended to diffuse the current crisis, evaluate the nature of the crisis, and intervene to reduce the likelihood of recurrence. Services are generally brief, 6 months, with appropriate follow-up and monitoring to assist in the transition to less intensive services. Services require prior authorization from Division of Medicaid(DOM) or its designee. Services have an annual limit of 270 per year. Services are provided a minimum of nine (9) direct contact hours per week. IOP-C/Y is an all-inclusive service designed to meet the clinical needs of the children/youth and their families. Providers must be certified by DMH for IOP-C/Y services, as well as, component parts of IOP-C/Y. Certification must include community support services and wraparound facilitation.

Phases of Crisis: Pre-Crisis Phase: An individual typically experiences an initial rise in tension and/or anxiety in response to a problem that occurs during his or her normal state of functioning. This phase includes some "precipitating event" to which an individual attempts to respond. The Impact Phase: This phase is usually caused by real or perceived lack of success in problem solving or coping with a particular situation. The more unsuccessful the attempts, the greater the increase in tension/anxiety and the more marked the psychiatric symptoms appear. The Crisis Phase: At the time of the crisis, an individual's resources/coping skills are not adequate to manage the presenting crisis. This result is a state of disequilibrium, whereby an individual's sense of balance is disrupted by an event or a series of events which creates a disruption in an individual's normal level of daily functioning. Immediate and direct intervention by the treatment provider or team is crucial to avoid an emergency situation. The Resolution Phase: The length of time it takes a person to reach resolution depends on many variables. The type and complexity of the problem, the person's coping skills, available resources, and her/his response to intervention. It is during this stage that understanding symptoms and evaluating the nature of the crisis is critical. The Post-Crisis Phase: This phase when an individual is "stabilized"

and the person's equilibrium has returned to homeostasis. It is during this time that working on more effective problem solving, relapse prevention, and accessing community and social support is important.
Eligibility: Individuals must be from birth to twenty one (21) years of age and meet the following criteria:

1. Exhibits one or more of the following symptoms to include, but not limited to:
    a. Behaviors/situations that manifest in ways that pose a threat to the individual and place them at high risk for out-of-home placement
    b. Depressive/anxiety symptomology
    c. Suicidal behaviors/ideation
    d. Self-injurious behaviors
    e. Crisis in which child/youth is at high risk for abuse and/or neglect
    f. Severe family distress/turmoil which results in safety concerns and places the child at high risk for out-of-home placement
    g. Psychotic symptoms of an acute nature or acute exacerbation of a chronic condition
    h. Crises arising due to co-occurring disorders of mood/anxiety and other disorders (i.e., substance use disorders)
2. The individual must be diagnosed by a psychiatrist or licensed psychologist with a mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria for SED specified in the current version of the DSM within the past sixty (60) days. The primary diagnosis must be psychiatric.
3. Have a full scale IQ of sixty (60) or above. If the full scale IQ is lower than sixty (60), there must be substantial evidence that the IQ score is suppressed due to psychiatric illness.
4. The evaluating psychiatrist or licensed psychologist indicates that the child/youth meets the criteria for Psychiatric Residential Treatment Facility (PRTF) level of care.
5. The child/youth is in need of specialized services and support from multiple agencies including community support services, targeted case management, and an array of clinical intervention and family supports.

Exclusionary criteria: The following exclusionary criteria applies to IOP-C/Y: a) Individuals age twenty one (21) or older, b) individuals with symptoms that do not meet criteria for PRTF, c) can be addressed through traditional outpatient services, d) determination by treatment team that imminent danger warrants admission to inpatient/PRTF, e) active substance use in which the treatment team determines referral to a substance abuse treatment facility is warranted, full scale IQ of less than 60 (except a identified in #3 above), or absence of primary Axis I diagnosis.

Team members: IOP-C/Y programs are required to have a Psychiatrist on staff, appropriate clinical staff to provide therapy services when needed, and availability of response 24 hour/7 days a week. Team members include the agency psychiatrist, licensed or certified outpatient therapist to provide appropriate therapy services, DMH certified community support specialist, team member trained in Wraparound Facilitation, Targeted Case Manager, and identified support system/family members.

Services: Services must be provided to children/youth based on the child/youth's needs as identified as a part of the wraparound or individual plan. An individualized plan must describe the services to be provided, frequency, providers of service with

qualifications identified, formal and informal supports available to the participant and family, and plan for anticipating, preventing, and managing crisis. Services include, but are not limited to, assessment and identification; crisis management/ intervention to prevent out-of-home placement, stabilize the living arrangement, and promote reunification; coordination of services and needed supports with other providers and/or natural supports; provide education on wellness, recovery, and resiliency; and development of crisis plan to reduce likelihood of reoccurrence.

Referrals: Referrals can come from a variety of sources such as, CCS personnel/treatment team, families/primary caregivers, school systems/personnel, hospitals/physicians/other medical personnel, DHS, law enforcement/judicial system, and other community agencies/concerned citizens

It is the responsibility of the County Administrator/Supervisor to ensure that all staff members who deliver IOP-C/Y shall be knowledgeable of the following: a) services offered by Community Counseling Services, including current entry criteria for each service, b) local community resources and how to access these services, c) procedures for making a referral to local MAP team, d) procedures for inpatient referral/commitment process should it be warranted, e) Crisis Phases, and f) principles of Wraparound services. All staff involved in IOP-C/Y must maintain certification in Crisis Prevention Intervention.

Accessing IOP-C/Y Services: During the business day, potential service recipients will be directed to the County Administrator/Supervisor or his/her designee, who will contact the appropriate outpatient therapist to conduct the initial assessment. During those times when Community Counseling Services offices are closed, services can be accessed as outlined in policy CES 02: Emergency Services.

Services: Evidenced-based and promising practices will be utilized as appropriate while allowing the individual/family to have input and maintain their right to choose the most appropriate treatment that meets the unique needs of their child/family.

Crisis Support Plan: Each individual receiving IOP-C/Y services must have on file an Individual Crisis Support Plan to develop a plan for anticipating, preventing, and managing crisis. This plan shall include formal and informal supports available to the individual and their family. The plan must be developed by the team of individuals who will be responsible for implementing the plan. Relevant history and potential crisis situations shall be identified, as well as, known triggers shall be indicated. Action steps shall be determined that outline the steps team members will take in the event the individual is experiencing a crisis and indicate who is responsible for initiating the response with appropriate contact information. All team members must have access to the plan so it can be referred to when needed.

Plan of Care: The plan of care will be implemented as follows:

1. Initial contact is made following referral for assessment
2. Determination severe, emotional and behavior disorder and that child/youth meets criteria for Psychiatric Residential Treatment Facility (PRTF) level of care
3. Appropriate action based on given situation to alleviate immediate distress/safety concerns

4. Intake scheduled/conducted
5. Individual Service Plan and Crisis Support Plan developed in consultation/with input from the individual and family
6. Service delivery will be provided as indicated on the Individual Service Plan - at a minimum, 9 direct contact hours will be provided each week
7. Linkage of families/primary care givers to family education/support services
8. Transition to less intensive services/traditional outpatient services will be made once the child/youth and family situation has stabilized

Mississippi Operational Standards addressed: Rule 22.2

Section: Child/Youth Mental Health
Policy: Wraparound Facilitation
Policy No.: CMH 07
Effective:
Revised/Approved: 3/28/2017

POLICY: It is the policy of Community Counseling Services to provide wraparound services to children/youth with severe emotional disturbance and their families. Wraparound services are designed to develop an individualized plan of care that addresses the unique and complex needs of the child/youth and their families so they can remain in their homes. The hopes, values, and preferences of the individual and his/her family are given primary importance during all phases and activities of wraparound.

PURPOSE: The purpose of wraparound services is to provide positive outcomes for children/youth that have unique and complex mental health needs. A holistic approach is utilized that involves increasing natural supports by strengthening interpersonal relationships and identifying resources that are available in the family's social network and community.

PROCEDURE: The wraparound process focuses on the strengths of the individual and his/her family while developing an individualized service plan that is effective and more relevant to the needs of the child/youth and their family. Emphasis is placed on involving the youth and increasing the families social support network. The wraparound process provides a structured, holistic, creative, and individualized team planning process. The team is comprised of individuals that are relevant to the child/youth and who collaboratively work together to develop and individualized plan of care.

Team members: Members of the team include, but are not limited to, a) child/youth (if age 9 or above) and there are no clear indications that participation by the youth would be detrimental, b) caregiver/guardian/parent, c) wraparound facilitator, d) service providers for the child/youth, e) representatives from service agencies involved with the child/youth and family, and f) identified supports/community members

Individuals appropriate for wraparound facilitation include:

a. Children/youth with serious mental health challenges who exceed the resources of a single agency or service provider
b. Children/youth who experience multiple acute hospital stays
c. Children/youth who are at risk of out-of-home placement or have been recommended for residential care
d. Children/youth who have had interruptions in the delivery of services across a variety of agencies due to frequent moves
e. Children/youth who have experienced failure to show improvement due to lack of previous coordination by agencies providing care, or reasons unknown can also be served through wraparound facilitation.

Phases of Wraparound

Engagement and team preparation: During this face the focus is on team building and embracing the shared vision of the child/youth, family, and team members. The families role is emphasized and their integral role in the process is reinforced. The individuals/families hopes, desires, and preferences are prioritized. Activities include orientation of the family and youth to wraparound, stabilize any presenting crisis/address pressing needs, explore strengths, needs, values, and vision with child/youth and family, engage/orient other team members, and arrange meeting arrangements.

Initial plan development: During this phase, trust and mutual respect between team members is built on from the previous phase. An initial, individualized plan of care is developed utilizing a planning process that incorporates wraparound principles. Activities include development of a plan of care, development of a crisis/safety plan, and complete necessary documentation.

Implementation: During this phase, the wraparound plan is implemented, monitored, and reviewed for changes/modifications. Team cohesiveness is maintained and/or activities incorporated to improve team dynamics and mutual respect. Activities include implementing the wraparound plan, assessing progress and updating plan as needed, continuing to build/maintain team cohesiveness and trust, and completing necessary documentation.

Transition: During this phase, a purposeful transition is made out of formal wraparound and to celebrate successes. Activities include creating a transition plan, a post transition crisis management plan, a commencement that celebrates successes and frames transition positively, and follow-up with family to monitor continued success.

Wraparound Facilitator Requirements: Wraparound Facilitators must meet the requirements as outlined in Policy HR 16: Qualifications of Staff

Service Delivery: Wraparound facilitation must be provided in accordance with high fidelity and quality wraparound practice. Activities should be aimed to recognize, identify, and develop talents, strengths, and positive abilities. Activities include:

a. Engaging the family
b. Assembling the child and family team
c. Facilitating a child and family team meeting at a minimum every thirty (30) days
d. Facilitating the creation of a plan of care, which includes a plan for anticipating, preventing and managing crisis, within the child and family team meeting
e. Working with the team in identifying providers of services and other community resources to meet family and youth needs
f. Making necessary referrals for youth
g. Documenting and maintaining all information regarding the plan of care, including revisions and child and family team meetings
h. Presenting plan of care for approval by the family and team

i. Providing copies of the plan of care to the entire team including the youth and family/guardian
j. Monitoring the implementation of the plan of care and revising if necessary to achieve outcomes
k. Maintaining communication between all child and family team members
l. Monitoring the progress toward needs met and whether or not the referral behaviors are decreasing
m. Leading the team to discuss and ensure the supports and services the youth and family are receiving continue to meet the caregiver and youth's needs
n. Educating new team members about the wraparound process
o. Maintaining team cohesiveness

MAP Team involvement: Those individuals involved in the wraparound process must have access to MAP team flexible funds in needed to carry out non-traditional services that have been incorporated into the individualized plan of care. Individuals accessing funds for non-traditional supports do not need to be reviewed by the MAP team to access these funds. Expenses will be documented in the plan and the MAP Team Coordinator will include the child/youth in the quarterly reports sent to DMH.

Mississippi Operational Standards addressed: Rule 41.1, 41.2