ALABAMA DEPARTMENT OF MENTAL HEALTH, MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES
ADMINISTRATIVE CODE

CHAPTER 580-2-20
PROGRAM OPERATION

580-2-20-.11 Mental Illness Outreach Services.

The agency shall have a separate program description for each Outreach Service/program. The program description shall include all requirements per 580-2-20-.09 (2) (a-e) General Clinical Practice and the program(s) criteria as follows:

(1) Adult Case Management.

(a) A description of the target population of erious mental illness (SMI).

(b) Age range.

(c) Nature and scope of the program, as indicated by the individual recipient needs and preferences.

(d) Location of the geographic services area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is case management.

(f) Admission criteria.

(g) Discharge/transfer criteria/procedures.

(h) The following services shall be delivered within the program:

1. Recipient Needs Assessment - A Case Management provider performs a written comprehensive assessment of the recipient's assets, deficits, and needs. The completed assessment shall be maintained in the recipient's file. The case management provider gathers the following information:

(i) Identifying information.

(ii) Socialization and recreational needs.

(iii) Training needs for community living.

(iv) Vocational needs.

(v) Physical needs.

(vi) Medical care concerns.

(vii) Social and emotional status.

(viii) Housing and physical environment.

(ix) Resource analysis and planning.

2. Case Planning - The development of a systematic, recipient-coordinated Plan of Care (POC) that:

(i) Lists the recipient's needs, strengths, and goals.

(ii) Lists the actions required to meet the identified needs of the recipient.

(iii) Is based on the needs assessment and is developed through a collaborative process involving the recipient, their family or other support system and the case manager.

(iv) Is completed in conjunction with the needs assessment within the first thirty (30) days of contact with the recipient and every six (6) months thereafter as long as the recipient is receiving case management services.

(v) Is approved by the supervisor.

3. Service arrangement - Through linkage and advocacy, the case manager coordinates contacts between the recipient and the appropriate person or agency. These contacts may be face-to-face, phone calls, or electronic communication.

4. Social Support - Through interviews with the recipient and significant others, the case manager determines whether the recipient possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the case manager assists the recipient in expanding or establishing such a network through advocacy and linking the recipient with appropriate persons, support groups, or agencies.

5. Reassessment and Follow-up - Through interviews and observations, the case manager evaluates the recipient's progress toward accomplishing the goals listed in the case plan at intervals of six (6) months or less. In addition, the case manager contacts persons or agencies providing services to the recipient and reviews the results of these contacts, together with the changes in the recipient's needs shown in the reassessments and revises the case plan if necessary.

6. Monitoring - The case manager determines what services have been delivered and whether they adequately meet

the needs of the recipient. The POC may require adjustments as a result of monitoring.

(i) Adult Case Management Services must be provided by a staff member with a bachelor's degree and who has completed a DMH approved Case Manager Training Program. Case managers who work with consumers who are deaf must complete training focusing on deafness and mental illness by DMH Office of Deaf Services.

(j) Adult Case Management Services for consumers who are deaf or who have limited English proficiency must be provided in a linguistically appropriate manner by staff proficient in the consumer's preferred language, or through the use of a qualified interpreter. Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(k) Adult Case Management Services are supervised by either a staff member who has a master's degree and who has successfully completed an ADMH approved case management supervisor training program, or bachelor's degree with three (3) years mental health case management experience who has successfully completed an ADMH approved case management training program.

(l) Case Managers must possess a valid current driver's license.

(m) Most Case Management Services and activities will occur on an outreach basis.

(n) The following documentation and/or forms are required and must be readily identifiable in the recipient's record:

1. Completed Needs Assessment using an ADMH approved assessment tool.

2. Plan of Care.

3. Progress/Service Notes - Notation by Case Manager of date, service duration, nature of service, and Case Manager's signature for each contact with the recipient or collateral.

4. Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

5. The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

6. Programming will be modified to provide effective participation for all recipients who are deaf.

(o) Authorization and consent forms as necessary to carry out case plans.

(2) Adult In-Home Intervention (IHI).

(a) A description of the target population of serious mental illness (SMI).

(b) Age range.

(c) Nature and scope of the Program, as indicated by individual recipient needs and preferences.

(d) A Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is Adult IHI.

(f) Admission criteria that includes at least the following:

1. Must meet criteria for Serious Mental Illness.

2. Must be eighteen (18) years of age or older and not otherwise meet the criteria for Transitional Age services.

3. Clearly documented need for more intensive

outpatient supports due to at least one (1) of the following:

(i) An increase in symptoms.

(ii) Transition from a more intensive level of service.

(iii) The need to defuse an immediate crisis situation.

(iv) The need to stabilize the living arrangement.

(v) The need to prevent out of home placement.

(vi) A history of failure to engage in other outpatient services.

(g) Discharge. Policies and procedures shall be developed and implemented for discharge from the program under any one or more of the following criteria:

1. The maximum benefits of the intensive in-home service have been reached.

2. The treatment plan goals have been met to the extent that the in-home therapy services are no longer needed.

3. The recipient/family has not responded to repeated, documented follow-up by the IHI team during a fourteen (14) day period.

4. The IHI team is unable to meet obvious, suspected or expressed needs of the child recipient and/or their family system.

5. The recipient becomes otherwise unavailable for services during a fourteen (14) day period.

(h) Transfer or referral to a different program

outside of IHI will occur when it is determined that the transfer will better meet the needs of the recipient. Transfer shall be considered under the following conditions:

1. The recipient is in need of more intensive services than the IHI team can provide.

2. The recipient is determined to be in need of less intensive services than those provided by the IHI team.

(i) Reflects the following characteristics and

philosophy of Adult In-Home Intervention:

1. Home-based treatment is provided by a two (2) person treatment team. Duration of treatment is determined on an individual basis as indicated on the treatment plan.

2. The team is the primary provider of services and is responsible for helping recipients in all aspects of community living.

3. The majority of services occur in the community and/ or in places where recipients spend their time.

4. Services are highly individualized both among individual recipients and across time for each recipient.

5. Persistent, creative adaptation of services to be acceptable to recipients provided in a manner of unconditional support.

(j) There must be an assigned team that is identifiable by job title, job description, and job function. IHI shall be provided by a two (2) member treatment team that is composed of one of the following options:

1. Rehabilitation Professional Option- One (1) professional with a master's degree in a mental health related field and one (1) professional with a bachelor's degree in a human services field or one (1) Certified Mental Health Peer Specialist – Adult; or

2. Registered Nurse Option- One (1) registered nurse under Alabama Law and one (1) professional with a bachelor's degree in a human services field. or Certified Mental Health Peer Specialist – Adult.

3. In each staffing composition, both team members must complete case management training. For Certified Mental Health Peer Specialist – Adult, they shall be certified by ADMH as a Certified Peer Specialist – Adult and maintain ADMH Certified Peer Specialist - Adult certification.

(k) The following key services must be delivered within the program when the team is composed of a master's level clinician and a case manager or Certified Mental Health Peer Specialist - Adult:

1. Individual and Family Therapy.

2. Crises Intervention.

3. Mental Health Consultation/Care Coordination.

4. Basic Living Skills.

5. Psychoeducational Services/Family Support.

6. Case Management/Care Coordination.

7. Medication Monitoring.

8. Peer Services, only when team member is a Certified Mental Health Peer Specialist – Adult.

(l) The following key services must be delivered within the program when the team is composed of a registered nurse and a case manager or Certified Mental Health Peer Specialist - Adult:

1. Crisis Intervention.

2. Mental Health Consultation/Care Coordination.

3. Basic Living Skills.

4. Psychoeducational Services/Family Support.

5. Case Management/Care Coordination.

6. Medication Monitoring.

7. Medication Administration.

8. Peer Services, only when team member is a Certified Mental Health Peer Specialist – Adult.

(m) The team must function in the following manner:

1. Services should be provided primarily as a team with the team members working individually as dictated by recipient need.

2. The hours of delivering the IHI services shall be flexible to accommodate the scheduling demands and unique issues of the target population (before 8:00 a.m. and after 5:00 p.m. as needed).

3. Documentation should reflect that IHI cases are staffed by the team on a regular basis and that joint decisions are made regarding the frequency of recipient contact for team and individual staff services.

4. The intensive nature of this service should be reflected in the average hours of direct service provided per person per week.

5. The active caseload for a team shall not exceed twenty (20) recipients.

(n) Recipients who are deaf or limited English proficient shall have effective communication access to these services provided by staff proficient in the recipient's preferred language a qualified interpreter. Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(o) Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

(p) The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

(q) Programming will be modified to provide effective participation for all recipients who are deaf._

(3) Assertive Community Treatment (ACT).

(a) A description of the target population of SMI.

(b) Age range.

(c) Nature and scope of the program as indicated by individual recipient needs and preferences.

(d) Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is specific to ACT.

(f) Admission criteria that include at least the following:

1. A psychiatric diagnosis.

2. Admission approval by a psychiatrist, licensed psychologist, or the clinical director.

(g) Discharge/transfer criteria and procedures.

(h) Reflects the following characteristics and philosophy of Assertive Community Treatment Teams:

1. Multi-disciplinary staff organized as a team in which members function interchangeably to provide treatment, rehabilitation, and support to persons with serious mental illness and severe functional disability.

2. The team is the primary provider of services and is responsible for helping recipients in all aspects of community living.

3. The majority of services occur in the community in places where recipients spend their time.

4. Services are highly individualized both among individual recipients and across time for each recipient.

5. Persistent, creative adaptation of services to be acceptable to recipients provided in a manner of unconditional support.

(i) The following services must be delivered within the program as indicated by recipient need:

1. Intake.

2. Medical assessment and treatment.

3. Medication administration.

4. Medication monitoring.

5. Individual, group and/or family therapy.

6. Case management.

7. Crisis intervention.

8. Mental health care coordination/consultation.

9. Psycho-educational services/Family support and education.

10. Basic living skills.

(j) There must be an assigned team that is identifiable by job title, job description, and job function. The team must have:

1. Part-time psychiatric coverage.

2. Three (3) full-time equivalent positions which include at least one (1) full-time master's level clinician.

3. At least .50 FTE registered nurse or licensed practical nurse, and

4. A fulltime case manager who has completed an approved case management training curriculum.

5. The remaining .5 FTE position may be filled at the agency's discretion by a master's level clinician, a nurse, a case manager, or a Certified Peer Specialist - Adult.

(k) The team must function in the following manner:

1. Each member of the team must be known to the recipient.

2. Each member of the team must individually provide services to each recipient in the team's caseload.

3. The team will conduct staffing of all assigned cases at least twice weekly.

4. The caseload cannot exceed a one to twelve (1:12) staff to recipient ratio where the part-time psychiatrist is not counted as one (1) staff member.

(l) The program coordinator must have a master's degree in a mental health service-related field and at least one (1) year of post-master's direct service experience or be a registered nurse with a minimum of one (1) year psychiatric experience.

(m) Services must be available and accessible, including effective communication access for recipients who are deaf, hard of hearing, or limited English proficient, to enrolled recipients

twenty-four (24) hours per day/seven (7) days per week in a manner and at locations that are most conducive to recipients' compliance with treatment and supports.

(n) It is not necessary that a member of the ACT team be on call at all times.

(o) The program does not limit length of stay.

(p) The number of contacts by individual team members and totally for the team varies according to individual recipient need, but shall be:

1. A minimum of once per week for recipients in a maintenance phase up to several times per day for recipients who require it.

2. Done in a manner to assure that all team members provide services to and are known to the recipient and are capable of stepping in when needed.

(q) Recipients who are deaf or limited English proficient shall have effective communication access to these services provided by staff proficient in the recipient's preferred language, or a qualified interpreter. Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(r) Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

(s) The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18)cannot be used as interpreters.

(t) Programming will be modified to provide effective participation for all recipients who are deaf.

(4) Program for Assertive Community Treatment (PACT).

(a) A description of the target population of SMI.

(b) Age range.

(c) Nature and scope of the program, as indicated by individual recipient needs and preferences.

(d) Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is specific to PACT.

(f) Admission criteria that includes at least the following:

1. Recipients with severe and persistent mental illnesses that seriously impair their functioning in community living. Priority is given to people with schizophrenia, other psychotic disorder, or bipolar disorders. At least eighty percent (80%) of recipients have a diagnosis of schizophrenia, bipolar or major depression.

2. Functional impairments demonstrated by at least one (1) of the following conditions:

(i) Inability to consistently perform the range of daily living tasks required for basic adult functioning in the community or persistent or recurrent failure to perform daily living tasks except with significant support or assistance from others such as friends, family, or relatives.

(ii) Inability to be consistently employed at a self-sustaining level or inability to consistently carry out the maintenance of living environment.

(iii) Inability to maintain a safe living situation.

3. Recipients with one (1) or more of the following which are indicators of continuous high-service needs (greater than eight (8) hours per month).

(i) Two or more admissions per year to acute psychiatric hospitals or psychiatric emergency services.

(ii) Intractable, severe major symptoms (affective, psychotic, suicidal).

(iii) Co-existing substance use disorder of significant duration (greater than six (6) months).

(iv) High risk of or recent criminal justice involvement.

(v) Inability to meet basic survival needs or residing in substandard housing, homeless, or at imminent risk of becoming homeless.

(vi) Residing in an inpatient bed or in a supervised community residence, but clinically assessed as being able to live in a more independent living situation if intensive services are provided or requiring residential/inpatient placement if more intensive services are not available.

4. Admission approval by a psychiatrist, CRNP/PA working under the supervision of a psychiatrist, licensed psychologist, or the Clinical Director.

(g) Discharge/transfer criteria and procedures that do not limit the amount of time a recipient is on the team, that permit the team to remain the contact point for all recipients as needed, and that require discharges to be mutually determined by the recipient and the team.

(h) The description reflects that the Program of Assertive Community Treatment (PACT) operates as follows:

1. Assumes responsibility for directly providing needed treatment, rehabilitation, and support services to identified recipients with sever and persistent mental illnesses.

2. Minimally refers recipients to outside service providers.

3. Provides services on a long-term care basis with continuity of caregivers over time.

4. Delivers seventy-five percent (75%) or more of the services outside program offices.

5. Emphasizes outreach, relationship building, and individualization of services.

(i) There must be an identifiable team with the following characteristics:

1. Clinical staff to recipient ratio of one to ten (1:10), excluding the doctor and administrative assistant.

2. Minimum team size of ten (10) FTE in urban areas, five to seven (5-7) FTE in rural areas.

3. A psychiatrist or CRNP/PA working under the supervision of a psychiatrist ten (10) hours per week per thirty (30) recipients.

4. Administrative Assistant of one (1) FTE in urban areas and .5 Full-time Equivalents in rural areas.

5. Full-time master’s level clinician as team leader.

6. At least eight (8) mental health professionals (MA, MSN, RN) in urban areas, five (5) mental health professionals (MA, MSN, RN) in rural areas.

7. Substance use disorder specialist of, at least, one (1) FTE.

8. RN, at least three (3) FTE in urban areas and one and a half (1.5) FTE in rural areas.

9. Vocational specialist of, at least, one (1) FTE.

10. Peer specialist of, at least, one (1) FTE.

11. Members that work as a team so that all team members know and work with all recipients.

(j) Program operates, at least, at eighty percent (80%) of full staffing for the past twelve (12) months, or since program opening, if not in operation for twelve (12) months.

(k) The team leader performs the following functions:

1. Leads daily organizational team meetings.

2. Leads treatment planning meetings.

3. Is available to team members for clinical consultation.

4. Provides one-to-one (1 to 1) supervision.

5. Functions as a practicing clinician.

(l) The psychiatrist or CRNP/PA under the supervision of a psychiatrist performs the following functions:

1. Conducts psychiatric and health assessments.

2. Supervises the psychiatric treatment of all recipients.

3. Provides psychopharmacologic treatment of all recipients.

4. Supervises the medication management system.

5. Provides individual supportive therapy.

6. Provides crisis intervention on-site.

7. Provides family interventions and psychoeducation.

8. Attends daily organizational and treatment planning meetings.

9. Provides clinical supervision.

(m) The registered nurses perform the following functions:

1. Manage medication system, in conjunction with doctors.

2. Administer and document medication treatment.

3. Conduct health assessments.

4. Coordinate services with other health providers.

(n) The vocational specialist performs the following functions:

1. Acts as the lead clinician for vocational assessment and planning.

2. Maintains liaison with Vocational Rehabilitation and training agencies.

3. Provides the full range of vocational services (job development, placement, job support, career counseling).

(o) The substance abuse specialist performs the following functions:

1. Serves on the individual treatment team of recipients with substance use disorder.

2. Acts as the lead clinician for assessing, planning, and treating substance use disorder.

3. Provides supportive and cognitive behavioral treatment individually and in groups.

4. Uses a stage-wise model that is non-confrontational, follows behavioral principles, considers interactions of mental illness and substance use disorder, and has gradual expectations of abstinence.

(p) The team provides outreach and continuity of care in the following manner:

1. At least seventy-five percent (75%) of all contacts occur out of the office.

2. Difficult-to-engage recipients are retained.

3. Difficult-to-engage recipients are seen two (2) times per month or more.

4. Acutely hospitalized recipients are seen two (2) times per week or more.

5. Long-term hospitalized recipients are seen each week in the hospital.

6. The team plans jointly with inpatient staff.

(q) The program provides the following intensity of services:

1. The program size does not exceed one hundred twenty (120) recipients in urban areas and eighty (80) in rural areas.

2. The staff to recipient ratio does not exceed one to ten (1:10).

3. The recipients are contacted face-to-face an average of three (3) times per week.

4. Unstable recipients are contacted multiple times daily.

(r) The team operates during the following hours:

1. The staff are on duty seven (7) days per week.

2. The program operates twelve (12) hours on weekdays.

3. The program operates eight (8) hours on weekends/ holidays.

4. The team members are on-call all other hours in the urban model.

5. In rural areas, team members can coordinate after-hours calls with other clinicians.

6. A team member must brief the on-call staff relative to high-risk recipients.

7. A team member must provide face-to-face services, if necessary.

(s) The team is organized and communicates in the following manner:

1. Organizational team meetings are held daily, Monday through Friday.

2. The daily meeting concludes within 45 - 60 minutes.

3. The status of each recipient is reviewed via daily log and staff report.

4. The team leader facilitates the discussion and treatment planning.

5. Services and contacts are scheduled per treatment plans and triage.

6. The shift manager determines the staff assignments.

7. The shift manager prepares the daily staff assignment schedule.

8. The shift manager monitors/coordinates service provision.

9. All staff contacts with recipients are logged.

(t) The team performs assessment and treatment planning in the following manner:

1. Baseline and ongoing assessments are documented in the following areas:

(i) Psychiatric.

(ii) Vocational.

(iii) Activities of daily living and housing.

(iv) Social.

(v) Family interaction.

(vi) Substance use.

(vii) Health.

2. Assessments are performed by qualified staff.

3. Individual treatment teams consist of from three to five (3:5) staff per recipient.

4. Treatment planning meetings are held weekly.

5. Treatment planning meetings are led by senior staff.

6. Recipients participate in formulating goals and service plans.

7. Problems, goals, and plans are specific and measurable.

8. The treatment plans are transferred to recipients' weekly schedules.

9. The treatment planning schedule is posted two (2) months in advance.

10. The treatment plan is reviewed and modified at key events in the course of treatment.

(u) Case management services are provided as follows:

1. A case manager is assigned for each recipient.

2. Other individual treatment team staff back-up the case manager.

3. The case manager provides supportive services, family support, education and collaboration, and crisis intervention.

4. The case manager plans, coordinates, and monitors services.

5. The case manager advocates for the recipient and provides social network support.

6. All staff perform case management functions.

(v) Crisis assessment and intervention services are provided as follows:

1. Crisis services are provided twenty-four (24) hours per day.

2. A team member is available by phone and face-to-face with back-up by team leader and psychiatrist in urban areas.

3. After-hour services are provided in rural areas either by the team or through collaboration with other emergency service providers.

(w) Individual supportive therapy is provided as follows:

1. Ongoing assessment of symptoms and treatment response.

2. Education about the illness and medication effects.

3. Symptom management education.

4. Psychological support, problem solving, and assistance in adapting to illness.

(x) Medication management is provided as follows:

1. The psychiatrist actively supervises/collaborates with the RN’s.

2. There is frequent assessment of recipient response by the psychiatrist.

3. All team members monitor medication effects/response.

4. Medication is managed in accordance with the policies and procedures.

(y) Substance use disorder services are provided as follows:

1. The team includes one (1) or more designated substance use disorder specialists.

2. All team members assess and monitor substance use.

3. Interventions follow an established co-occurring disorders treatment model.

4. Individual interventions are provided.

5. Group interventions are provided.

(z) Work-related services are provided as follows:

1. Services include an assessment of interest and abilities and of effect of mental illness on employment.

2. All team members provide vocational services that are coordinated by the team vocational specialist.

3. An ongoing employment rehabilitation plan is developed.

4. On-the-job collaboration with the recipient and supervisor is provided.

5. Off-the-job work-related supportive services are provided.

(aa) Services for activities of daily living include the following training:

1. Self-care skills.

2. Maintenance of living environment skills.

3. Financial management skills.

4. Use of available transportation.

5. Use of health and social services.

(bb) The team organizes leisure time activities. Services for social, interpersonal relationship, and leisure time include the following:

1. Communication skill training.

2. Interpersonal relations skill training.

3. Social skills training.

4. Leisure time skills training.

5. Support to recipients in participating in social, recreational, educational, and cultural community activities.

(cc) Support services are provided and include the following:

1. Access to medical and dental services.

2. Assistance in finding and maintaining safe, clean affordable housing.

3. Financial management support.

4. Access to social services.

5. Transportation and access to transportation.

6. Legal advocacy.

(dd) Recipients who are deaf or have limited English proficiency shall have effective communication access to these services provided by staff proficient in the recipient's preferred language, or by a qualified interpreter. Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(ee) Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

(ff) The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

(gg) Programming will be modified to provide effective participation for all recipients who are deaf.

(5) Individual Placement and Support – Supported Employment (IPS-SEP).

(a) A description of the target population of serious mental illness (SMI).

(b) Age range.

(c) Nature and scope of the program, as indicated by individual recipient needs and preferences.

(d) Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is IPS-SEP.

(f) Admission criteria shall address inclusionary criteria as follows:

1. Presence of a psychiatric diagnosis.

2. Mild to moderate persistent, chronic, and/or refractory symptoms and impairments in one (1) or more areas of living (e.g., difficulty attaining & sustaining life goals and/or community integration).

3. Recipient has expressed interest in employment as a recovery goal.

(g) IPS-SEP services are reasonably expected to improve the individual's functional level, increase quality of life, and facilitate attainment of personal life goals to include goals for competitive employment or supported education.

(h) Once determined to need admission criteria, no exclusionary criteria for IPS-SEP shall be implemented. Recipients are not screened out formally or informally. All recipients interested in working have access to IPS-SEP regardless of job readiness factors, substance use disorder, symptoms, history of violent behavior, cognition impairments, treatment non-adherence, and personal presentation.

(i) Discharge/transfer criteria shall include the following:

1. Employment or educational goals have been met and the individual no longer needs this type of service.

2. The individual chooses to no longer participate.

(j) The program does not limit length of stay.

(k) IPS-SEP constitutes services and supports that specifically address the individual's employment/educational goals. The IPS-SEP should include an individualized employment goal identified on the treatment plan. Based upon the individual's needs and preferences, the following services shall be provided at a minimum by the IPS-SEP:

1. Vocational profile and assessment.

2. Employment Search Plan to include career/education/ training.

3. Rapid Job Search/Job Development.

4. Job coaching/On the job supports.

5. Follow Along Employment/Education Supports.

6. Assertive Engagement and Outreach.

7. Benefits/Incentives Planning.

8. Peer Support.

(l) There must be an identifiable team with the following staff configuration and credentials:

1. The part-time Program Coordinator shall serve as the team leader/supervisor. The coordinator shall have a bachelor's degree in a human services field or alternatively, two years' experience working as an IPS-SEP team member. The supervisor shall complete the ADMH approved IPS-SEP Supervisor's training within the first six (6) months of hire.

2. At minimum, two (2) full-time Employment Specialists shall have a high school diploma or equivalent with either knowledge of the field of employment or experience in providing services to individuals with serious mental illness and/or providing employment services to disabled populations. The Employment Specialist shall complete the ADMH approved IPS-SEP Practitioner's training within the first six (6) months of hire.

3. One (1) full-time or two (2) part-time MI Adult Peer Specialist(s) who successfully complete peer specialist certification through ADMH within first six (6) months of hire and possess a high school diploma or equivalent.

4. One (1) full-time Benefits Specialist must possess either a nationally approved certification recognized by ADMH or will have a high school diploma or equivalent and obtain a nationally approved certification recognized by ADMH within the first twelve (12) months of hire.

(m) The team shall function and provide activities in the following manner:

1. Employment Specialists shall maintain a staff to recipient ratio of no greater than one to twenty (1:20).

2. Individualized benefits plan before starting a job.

3. IPS-SEP Team may be available after hours on a case-by-case basis as needed for provision of services.

(n) The Team leader (IPS-SEP Supervisor) shall preform the following functions:

1. Conduct weekly group supervision with IPS-SEP team focusing on recipient goals, employer relationships, and celebrations.

2. Conduct field mentoring activities.

(o) Recipients who are deaf or limited English proficient shall have effective communication access to these services provided by staff proficient in the recipient's preferred language, or a qualified interpreter. Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(p) Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

(q) The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

(r) Programming will be modified to provide effective participation for all recipients who are deaf.

(6) First Episode Psychosis Program (FEP).

(a) A description of the target population of serious mental illness (SMI)/serious emotional disturbance (SED).

(b) Age range.

(c) Nature and scope of the program, as indicated by individual recipient needs and preferences.

(d) Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is specific to FEP.

(f) Admission criteria that include at least the following:

1. Presence of a primary diagnosis of a psychotic/affective disorder as approved by ADMH.

2. Age range from 15-25 years at initiation of services.

3. Recipient must agree to participate in treatment.

4. Recipient must require intensive treatment not available in a less restrictive program and must be experiencing one (1) or more of the following symptoms:

(i) Hallucinations or delusions.

(ii) Other psychotic symptoms.

(iii) Impaired contact with reality.

(iv) Social withdrawal and confusion not warranting hospitalization.

(v) Mild to severe symptoms of mania.

(vi) Mild to severe or disabling anxiety.

(vii) Inappropriate problem-solving skills.

(viii) Inappropriate attention seeking behavior.

(ix) Poor adherence to medication regiment or immediate need for medication.

5. Admission is approved by a Licensed Independent Practitioner.

(g) Exclusionary criteria must be included. All recipients receiving treatment from the program will be evaluated at admission and periodically after admission to determine if any of the following exclusionary criteria are met. If a recipient is found to meet one (1) or more of the following criteria, the recipient will be provided with a referral to the appropriate treatment setting. Exclusionary criteria include the following:

1. The needs identified in the referral to FEP does not meet admission criteria.

2. The needs identified in the referral to FEP are not directly related to a primary SMI diagnosis.

3. The recipient is placed in a hospital and/or Child and Adolescent Psychiatric Residential Treatment Facility (PRTF) setting and is not expected to discharge within ninety to one hundred eighty (90 to 180) days.

4. Recipient has a primary diagnosis of substance use disorder.

5. Recipient has primary diagnosis of a physical illness that requires a more intensive treatment setting which precludes participation in treatment in an ambulatory treatment setting.

6. Recipient has a primary diagnosis of an organic or neurological mental disorder that precludes participation in treatment in an ambulatory treatment setting.

7. Recipient has a primary diagnosis of an intellectual/developmental disability, to include autism spectrum disorder (ASD).

(h) Discharge/transfer criteria and procedures shall be developed. This setting is not designed to provide long term outpatient care. Each recipient engaged in care through the program will have the next treatment provider identified by the end of the second year of treatment. Recipients shall be considered for discharge if one (1) or more of the following conditions are met:

1. Recipient is found to meet one (1) or more of the exclusionary criteria.

2. Recipient fails to adhere to the treatment plan established jointly by the recipient and treatment team.

3. All goals on the treatment plan have been met.

(i) First Episode Psychosis Program Reflects the following characteristics and philosophy of the:

1. Trans-disciplinary staff organized as a team in

which members function interchangeably to provide treatment, rehabilitation and support to recipients experiencing psychosis.

2. The team is the primary provider of services and is responsible for helping recipients in all aspects of community living.

3. The majority of services occur in the community in places where recipients spend their time.

4. Services are highly individualized both among individual recipients and across time for each recipient.

5. Emphasizes outreach, relationship building, and individualization of services.

(j) There shall be an identifiable team with the following characteristics:

1. Clinical staff to consumer ratio of one to ten (1:10), excluding the psychiatrist and nurse.

2. A Master's level clinical coordinator of, at least, one (1) FTE who has at least two (2) years of treatment experience in a mental health setting.

3. A psychiatrist, Physician Assistant (PA) or Certified Registered Nurse Practitioner (CRNP) working under the supervision of a psychiatrist, of, at least, .33 FTE.

4. A licensed practical nurse or registered nurse of, at least, .5 FTE

5. A Care Coordinator of, at least, one (1) FTE who has a minimum of a bachelor's level degree and has completed the ADMH approved Child and Adolescent Intensive Care Coordination Training.

6. A Supported Employment/Education Specialist of, at least, one (1) FTE who has a minimum of a high school diploma or equivalent and has completed the ADMH Individualized Placement Support – Supported Employment (IPS- SEP) and the ADMH approved Child and Adolescent Intensive Care Coordination Trainings.

7. A Certified Peer Specialist-Youth of, at least, .5 FTE who has completed the ADMH approved Certified Peer Specialist – Youth Training.

8. A Certified Peer Specialist-Parent of, at least, .5 FTE who has completed the ADMH approved Certified Peer Specialist – Parent Training.

9. Each team member is responsible for performing all the specific duties and responsibilities identified for their position as outlined in the FEP Model. The team members will adhere to the fidelity of the identified model.

10. Members work as a team so that the entire team knows and works with all recipients.

11. FEP services are supervised by a staff member who has a master's degree and two (2) years of post-master's clinical experience and who has completed an ADMH approved Intensive Care Coordination Training. The record shall document a minimum of one (1) hour of face-to-face staffing consultation with the supervisor weekly as documented in clinical chart and shall include any recommendations made to the team.

(k) The following services must be delivered within the program as appropriate for the recipient:

1. Intake Evaluation.

2. A systematic determination of the specific human service needs of each recipient and their family (if appropriate) as well as a clinical assessment that demonstrates the need for this level of service. The needs determination shall be based upon the approved ADMH functional assessment tool.

3. Person Centered Treatment Planning with the development of a written plan that is completed by the fifth face-to-face or by the thirtieth (30^{th}) day of enrollment.

4. Individual Therapy/Counseling.

5. Family Therapy/Counseling.

6. Group Therapy/Counseling.

7. Psychoeducational Services (Family Support).

8. Physician Assessment and Treatment.

9. Medication Administration.

10. Medication Monitoring.

11. Crisis Intervention and Resolution.

12. Pre-Hospitalization Screening.

13. Mental Health Care Coordination/Case Consultation.

14. Intensive Care Coordination/Case Management.

15. Community Integration Support Services.

16. Education/Employment Support Services.

17. Youth Peer Support Services.

18. Family Peer Support Services.

19. Basic Living Skills.

20. Community Outreach to educate the community regarding services and the referral process.

21. Treatment Plan Review.

(l) The Team shall function in the following manner:

1. The team will convene a staffing of active recipients at a minimum of one (1) time per week.

2. The hours of delivering the FEP services shall be flexible to accommodate the scheduling demands and unique issues of the target population (before 8:00 a.m. and after 5:00 pm as needed).

(m) The anticipated length of stay for the FEP program is two (2) years.

1. The FEP team has the option of extending services for an additional one (1) year if treatment needs are clearly indicated, with prior approval from ADMH.

(n) Upon discharge from the FEP program, the team will link the recipient and family to follow up services as appropriate.

(o) Recipients who are deaf or limited English proficient shall have effective communication access to these services provided by staff proficient in the recipient's preferred language, or a qualified interpreter. Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(p) Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

(q) The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

(r) Programming will be modified to provide effective participation for all recipients who are deaf

(7) Child and Adolescent Low Intensity Care Coordination (LICC).

(a) A description of the target population of SED/SMI.

(b) Age range.

(c) Nature and scope of the program, as indicated by individual recipient needs and preferences.

(d) Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is specific to LICC.

(f) Admission criteria.

(g) Discharge/transfer criteria and procedures shall include:

1. The treatment plan goals have been met to the extent that LICC is no longer needed to prevent worsening of the recipient's mental health needs.

2. The recipient is placed in a hospital, psychiatric residential treatment facility, or other residential treatment setting and is not expected to discharge within ninety to hundred-eighty (90 to 180) days.

3. Required consent for treatment is withdrawn.

4. The recipient is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care, and this level of care is not required to prevent worsening of the recipient's mental health condition.

(h) Exclusionary Criteria includes any of the following:

1. The needs identified in the referral to LICC do not meet admission criteria.

2. The needs identified in the referral to LICC are not directly related to a primary SED or SMI diagnosis. Individuals with the following conditions are excluded from admission unless there is a psychiatric condition co-occurring with one (1) of the following diagnoses:

(i) Substance Use Disorder.

(ii) Developmental Disability.

(iii) Autism.

(iv) Organic Mental Disorder.

(v) Traumatic Brain Injury.

3. The person(s) with authority to consent to medical treatment for the youth does not voluntarily consent to participate in LICC.

4. The recipient is placed in a hospital, psychiatric residential treatment facility, or other residential treatment setting and is not expected to discharge within ninety to one hundred-eighty (90 to 180) days.

(i) The following services shall be delivered within the program:

1. Recipient Needs Assessment - A LICC provider performs a written comprehensive assessment of the recipient’s assets, deficits, and needs. The completed assessment shall be maintained in the recipient’s file. The LICC provider gathers the following information:

(i) Identifying information.

(ii) Socialization and recreational needs.

(iii) Training needs for community living.

(iv) Vocational needs.

(v) Physical needs.

(vi) Medical care concerns.

(vii) Social and emotional status.

(viii) Housing and physical environment.

(ix) Resource analysis and planning.

(x) The needs assessment must be completed or reviewed within fourteen (14) days of the first face-to-face care coordination contact and reviewed/updated every six (6) months or less thereafter as long as the recipient is receiving services (LICC).

2. Case Planning - The development of a systematic, recipient-coordinated Plan of Care (POC) that:

(i) Lists the recipient's needs, strengths, and goals.

(ii) Lists the actions required to meet the identified needs of the recipient.

(iii) Is based on the needs assessment and is developed through a collaborative process involving the recipient, their family or other support system and the care coordinator.

(iv) Is completed in conjunction with the needs assessment within the first thirty (30) days of contact with the recipient and every six (6) months thereafter as long as the recipient is receiving LICC services.

(v) Is approved by the supervisor.

3. Service arrangement - Through linkage and advocacy, the care coordinator coordinates contacts between the recipient and the appropriate person or agency. These contacts may be face-to-face, phone calls, or electronic communication.

4. Social Support - Through interviews with the recipient and significant others, the care coordinator determines whether the recipient possesses an adequate personal support system. If this personal support system is inadequate or nonexistent, the care coordinator assists the recipient in expanding or establishing such a network through advocacy and linking the recipient with appropriate persons, support groups, or agencies.

5. Reassessment and Follow-up - Through interviews and observations, the care coordinator evaluates the recipient's progress toward accomplishing the goals listed in the case plan at intervals of six months or less. In addition, the care coordinator contacts persons or agencies providing services to the recipient and reviews the results of these contacts,

together with the changes in the recipient's needs shown in the reassessments and revises the case plan if necessary.

6. Monitoring - The care coordinator determines what services have been delivered and whether they adequately meet the needs of the recipient. The POC may require adjustments as a result of monitoring.

(j) LICC Services shall be provided by a staff member with a bachelor's degree and who has completed a Child and Adolescent ADMH approved Case Management Training Program. Care coordinators who work with recipients who are deaf must complete training focusing on deafness and mental illness by ADMH Office of Deaf Services.

(k) LICC Services for recipients who are deaf or limited English proficient shall have effective communication access to these services provided by:

1. Staff fluent in the recipient's preferred language, or

2. A qualified interpreter.

3. Staff working with recipients who are deaf shall have at least an Intermediate Plus level on the Sign Language Proficiency Interview.

4. Programming will be modified to provide effective participation for all recipients who are deaf.

(l) Child and Adolescent LICC Services are supervised by either a staff member who has a master's degree who has successfully completed an ADMH approved child and adolescent LICC training program or bachelor's degree with three (3) years child and adolescent mental health Case Management/care coordination experience who has successfully completed an ADMH approved child and adolescent case management/care coordination training program.

(m) Care coordinators must possess a current valid driver's license.

(n) Most LICC services and activities will occur on an outreach basis.

(o) The following documentation and/or forms are required and must be readily identifiable in the recipient's record or on the ADMH website (for needs assessment):

1. Completed or reviewed Needs Assessment using an ADMH approved assessment tool.

2. Plan of Care

3. Progress/Service Notes - Notation by care coordinator of date, service duration, nature of service, and care coordinator's signature for each contact with the recipient or collateral.

4. Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

(p) Services for recipients who are deaf or who have limited English proficiency must be provided in a linguistically appropriate manner by staff proficient in the recipient's preferred language, or through the use of a qualified interpreter Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(q) The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

(r) Programming will be modified to provide effective participation for all recipients who are deaf.

(s) Authorization and consent forms as necessary to carry out care plans.

(8) Child and Adolescent High Intensity Care Coordination (HICC).

(a) A description of the target population of serious emotional disturbance (SED) and/or a serious mental illness (SMI).

(b) Age range.

(c) Nature and scope of the program, as indicated by individual recipient needs and preferences.

(d) Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is specific to HICC.

(f) Admission criteria includes presence of a SED and/or a SMI; and at least one (1) of the following:

1. The recipient is involved in multiple child-serving systems or is at risk.

2. The recipient has more intensive needs (such as admissions to inpatient psychiatric hospitals and/or residential) or is at risk.

3. The recipient's treatment requires cross-agency collaboration.

(g) Discharge/transfer criteria/procedures. Discharge criteria includes the following:

1. The treatment plan goals have been met to the extent that HICC is no longer needed to prevent worsening of the recipient's mental health needs.

2. The recipient is not engaged in treatment during a ninety (90) day period despite multiple, documented attempts to address engagement or lack thereof.

3. The recipient is placed in a hospital, psychiatric residential treatment facility, or other residential treatment setting and is not expected to discharge within ninety to hundred-eighty (90 to 180) days.

4. Required consent for treatment is withdrawn.

5. The recipient is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care, and this level of care is not required to prevent worsening of the recipient's mental health condition.

6. Exclusionary Criteria includes any of the following:

(i) The needs identified in the referral to HICC do not meet admission criteria.

(ii) The needs identified in the referral to HICC are not directly related to a primary SED or SMI diagnosis. Individuals with the following conditions are excluded from admission unless there is a psychiatric condition co-occurring with one (1) of the following diagnoses:

(I) Substance Use Disorder.

(II) Developmental Disability.

(III) Autism.

(IV) Organic Mental Disorder.

(V) Traumatic Brain Injury.

(iii) The person(s) with authority to consent to medical treatment for the youth does not voluntarily consent to participate in HICC.

(iv) The recipient is placed in a hospital, psychiatric residential treatment facility, or other residential treatment setting and is not expected to discharge within ninety to one hundred-eighty (90 to 180) days.

7. Continued stay criteria includes the following:

(i) The recipient is continuing to make progress toward treatment goals and there is a reasonable expectation of progress at this level of care; or

(ii) This level of care is required to prevent worsening of the recipient's mental health condition.

(h) The following services must be delivered within the program:

1. The first face-to-face appointment within seven (7) days of the recipient's acceptance of HICC.

2. The ADMH approved Functional Assessment must be completed or reviewed with the recipient within fourteen (14) days of the first face-to-face care coordination contact and reviewed/updated with the recipient every six (6) months or less thereafter as long as the recipient is receiving HICC services.

3. The ADMH approved Crisis Stabilization and Support Plan must be completed or reviewed with the recipient within fourteen (14) days of the first face-to-face care coordination contact and reviewed and updated regularly, but at a minimum of every six (6) months.

4. The development of a systematic, recipient-coordinated Plan of Care (POC)must be completed within thirty (30) days of the first face-to-face care coordination contact with the recipient and every six months thereafter as long as the recipient is receiving HICC services. The HICC is required to convene the child and family team (CFT) to complete the POC. All POCs must be approved by the supervisor.

5. Service arrangement - Through linkage and advocacy, the HICC coordinates contacts between the recipient and the appropriate person or agency. These contacts may be face-to-face, phone calls, or electronic communication.

6. Social Support - Through interviews with the recipient and significant others, the HICC determines whether the recipient possesses an adequate personal support system. If

this personal support system is inadequate or nonexistent, the HICC assists the recipient in expanding or establishing such a network through advocacy and linking the recipient with appropriate persons, support groups, or agencies.

7. Reassessment and Follow-up - Through interviews and observations, the HICC evaluates the recipient's progress toward accomplishing the goals listed in the POC at intervals of six (6) months or less. In addition, the HICC contacts persons or agencies providing services to the recipient and reviews the results of these contacts, together with the changes in the recipient's needs shown in the reassessments and revises the POC if necessary.

8. Monitoring - The HICC determines what services have been delivered and whether they adequately meet the needs of the recipient. The POC may require adjustments as a result of monitoring.

(i) HICC Services must be provided by a staff member with a bachelor's degree in a human service-related field or a registered nurse. Both shall complete an ADMH approved Child and Adolescent Intensive Care Coordination Training Program within an ADMH approved timeline.

(j) HICC who work with recipients who are deaf must complete training focusing on deafness and mental illness by ADMH Office of Deaf Services.

(k) Child and Adolescent HICC Services are supervised by either a staff member who has a master's degree who has successfully completed an ADMH approved Child and Adolescent Intensive Care Coordination Training Program or bachelor's degree in a human service field with three (3) years child and adolescent mental health case management/care coordination experience who has successfully completed an ADMH Child and Adolescent Intensive Care Coordination Training Program.

(l) The active caseload for a HICC shall not exceed eighteen (18) Recipients.

(m) HICCs must possess a current valid driver's License.

(n) Most HICC Services and activities will occur on an outreach basis.

(o) The following documentation and/or forms are required and must be readily identifiable in the recipient's record or on the ADMH website:

1. Completed or reviewed Functional Assessment using ADMH approved assessment tool.

2. Plan of Care – Goals, methods of accomplishment, and approval of same by HICC supervisor.

3. Service Notes - Notation by HICC of date, service duration, nature of service, and HICC's signature for each contact with the recipient or collateral.

4. Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

5. The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

(p) Services for recipients who are deaf or who have limited English proficiency must be provided in a linguistically appropriate manner by staff proficient in the recipient's preferred language, or through the use of a qualified interpreter Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(q) Programming will be modified to provide effective participation for all recipients who are deaf.

(r) Authorization and consent forms as necessary to carry out case plans.

(9) Child and Adolescent In-Home Intervention.

(a) A description of the target population of serious emotional disturbance (SED)/serious mental illness (SMI).

(b) Age range.

(c) Nature and scope of the program, as indicated by individual recipient needs and preferences.

(d) Location of the geographic service area for the program.

(e) Specifies that the program is staffed by qualified individuals whose primary job function is specific to Child and Adolescent In-Home Intervention.

(f) Admission criteria that include at least the following:

1. Presence of a serious emotional disturbance (SED and/or serious mental illness (SMI).

2. Age ranges from five to twenty (5-20) years (exception of Transitional Age specialized teams which are age range of 17-25).

3. IQ of 70 or above (exception of MI/ID specialized teams in which both team members have documentation in their personnel file of at least five (5) hours of training specific to addressing the ID/DD population within one (1) year from the date they began providing services, with two (2) hours annually thereafter. In addition, they must complete the required ten (10) hours training within one (1) year from the date they began providing such services for the specialty population of children and adolescents).

4. Clearly documented need to defuse a crisis situation, stabilize the family unit, or reduce the likelihood of the need for more intensive or restrictive services.

5. The recipient resides in a family home environment (e.g., foster, adoptive, birth, kinship).

6. Admission is approved by a Licensed Independent Practitioner.

(g) Discharge criteria. Policies and procedures shall be developed and implemented for discharge from the program under one (1) or more of the following criteria:

1. The treatment plan goals have been met to the extent that the intensive in-home therapy services are no longer needed to prevent worsening of the recipient’s mental health needs.

2. The recipient is not engaged in treatment during a fourteen (14) day period despite multiple documented attempts to address engagement or lack thereof.

3. The IHI team is unable to meet obvious, suspected or expressed needs of the recipient.

4. The recipient is placed in a hospital, skilled nursing facility, psychiatric residential treatment facility, or other residential treatment setting.

5. Required consent for treatment is withdrawn.

6. The recipient is not making progress toward treatment goals and there is no reasonable expectation of progress at this level of care, and this level of care is not required to prevent worsening of the recipient’s mental health condition.

(h) Transfer or referral to a different program outside of IHI will occur when it is determined that the transfer will better meet the needs of the recipient and/or family. Transfer or referral shall be considered under the following conditions:

1. The recipient is in need of more intensive services than the IHI team can provide.

2. The recipient is determined to be in need of less intensive services than those dictated by the IHI model and therefore recipient is no longer in need of more intensive or restrictive services.

3. The child or adolescent recipient and his/her family are receiving duplicate services from another child-serving agency that either cannot be terminated or are preferred by the family in lieu of IHI services.

(i) Exclusionary criteria that include any of the following:

1. The needs identified in the referral to IHI does not meet admission criteria.

2. The needs identified in the referral to IHI services are not directly related to a primary SED or SMI diagnosis; or

3. Individuals with the following conditions are excluded from admission unless there is a psychiatric condition co-occurring with one (1) of the following diagnoses:

(i) Substance Use Disorder.

(ii) Developmental Disability.

(iii) Autism.

(iv) Organic Mental Disorder.

(v) Traumatic Brain Injury.

4. The recipient is in a hospital, skilled nursing facility, psychiatric residential treatment facility or other residential treatment setting at the time of referral and is not ready for discharge to a family home environment or community setting with community-based supports.

5. The needs identified in the treatment plan that would be addressed by IHI services are being fully met by other less restrictive community-based services.

6. The recipient has severe medical conditions or impairments that would prevent any beneficial utilization of IHI services.

(j) Continued stay criteria include the following:

1. The recipient is continuing to make progress toward treatment goals and there is a reasonalbe expectation of prograss at this level of care; or

2. This level of care is required to prevent worsening of the recipient's mental health condition.

(k) Reflects the following characteristics and

philosophy of In-Home Intervention:

1. Time-limited, home-based services provided by a two (2) person team consistent with wrap-around principles and process. IHI services are limited to twelve (12) weeks, subject to two (2) clinical extensions of up to four (4) weeks each and additional extensions via the ADMH approved prior authorization process.

2. The team is the primary provider of services and is responsible for helping recipients and/or family in of community living.

3. The majority of services occur in the community in places where recipients spend their time.

4. If not previously assessed with completion of a Psychosocial Assessment/Intake, the IHI team can perform the Psychosocial Assessment/Intake as part of the bundled service delivery.

(l) The following services must be delivered within the program:

1. A systematic determination of the specific human service needs of each recipient and/or family, as well as a comprehensive community-based mental health assessment that demonstrates the need for this level of service. The needs determination must be based upon the approved the ADMH assessment tool(s) and be completed or reviewed with the recipient and/or family within the first fourteen (14) days of enrollment.

2. The development of an approved ADMH Crisis Stabilization and Support Plan (CS&SP) with the youth and/or

family, or review if already completed, by the fourteenth (14^{th}) day of the first face-to-face contact. The CS&SP shall be developed with input from the youth, family, and support individuals identified on the plan.

3. The development of a treatment plan based on the strengths and needs of the recipient as identified by the ADMH approved functional assessment tool, the recipient, and/or the recipient's family shall be completed by the thirtieth (30^{th}) day of enrollment.

4. Individual Therapy.

5. Family Counseling.

6. Psychoeducation (Family Support and Education).

7. Basic Living Skills.

8. Crisis Intervention twenty-four (24) hour availability.

9. Medication Monitoring.

10. Mental Health Coordination/Case Consultation.

11. Treatment Plan Review.

(m) There must be an assigned team that is identifiable by job title, job description, and job function. IHI shall be provided by a two (2) member treatment team that is composed of the following:

1. One (1) professional with a master's degree in a mental health-related field or a registered nurse licensed under Alabama law, who has completed a master's degree in psychiatric nursing; and

2. One (1) professional with a bachelor's degree in a human services field or a Certified Peer Specialist – Youth Parent.

3. Both team members must have completed an ADMH approved an In-Home Intervention Training program as documented in personnel records. In addition, the Certified Peer Specialist – Parent must successfully complete an ADMH approved Certified Peer Specialist – Parent training as documented in personnel records.

(n) The team shall function in the following manner:

1. The majority of the IHI services are to be delivered with the team member together at a frequency of two (2) to three (3) direct face-to-face contacts per week during the Assessment Phase; two (2) to five (5) direct face-to face contacts per week in the Treatment Phase; and one (1) to two (2) direct face-to-face contacts per week during the Generalization Phase.

2. The hours of delivering the IHI services shall be flexible to accommodate the scheduling demands and unique issues of the target population (before 8:00 a.m. and after 5:00 pm as needed).

3. Documentation reflects those services are provided primarily by both team members in attendance. If In-Home Intervention services are discontinued, enrollees are referred to other services when the team is no longer a two (2) person team. Examples would include the loss of one (1) of the team members, extended illness, maternity leave, etc. exceeding a two (2) week period.

4. The active caseload for a team shall not exceed six (6) recipients and their families.

5. The intensive nature of this service shall be reflected in the average hours of direct service provided per family per week and documented in the recipient record.

(o) IHI services are supervised by a staff member who has a master's degree and two (2) years of post-master's clinical experience and who has successfully completed an ADMH approved intensive In-Home Intervention training program. The record shall document a minimum of one (1) hour of face-to-face staffing consultation with the supervisor every two (2) weeks as documented in recipient's record and shall include any recommendations made to the team.

(p) Recipients who are deaf, or limited English proficient shall have effective communication access to these services provided by staff proficient in the recipient's preferred language, or a qualified interpreter. Proficient in American Sign Language is defined as having at least an Intermediate Plus level on the Sign Language Proficiency Interview.

(q) Documentation that communication access has been provided for recipients who are deaf or who have limited English proficiency.

(r) The use of family members to interpret is discouraged due to the possibility of conflicts of interest. If family members are used to interpret, this shall be noted on the waiver. Family members under the age of eighteen (18) cannot be used as interpreters.

(s) Programming will be modified to provide effective participation for all recipients who are deaf.

(t) IHI shall reflect the following characteristics and philosophy of Child and Adolescent In-Home Intervention:

1. IHI services and activities shall be provided on an outreach basis. IHI services, while by definition and practice are usually provided in the recipient's home, infrequently may be provided in other locations such as schools, juvenile court, a local park, or clinic, etc.

2. The IHI team's priorities shall include:

(i) Intervening in a crisis situation.

(ii) Stabilizing the family's ability to effectively manage the child recipient's mental health symptoms.

(iii) Facilitating the reunification of a recipient back into their family upon return from a more restrictive treatment placement/facility.

(iv) Working with the recipient and/or family to implement interventions to advance therapeutic goals or improve ineffective patterns of interaction.

(v) Coordination with external agencies and stakeholders that may impact the recipient's treatment plan.

(vi) Referral and linkage to appropriate services along the continuum of care.

(vii) Coaching in support of decision-making in both crisis and non-crisis situations.

(viii) Skill development for the recipient and/or family.

(ix) Monitoring progress on attainment of treatment plan goals and objectives.

(u) During Assessment Phase, week one (1) to four

(4) IHI team shall:

1. Complete an initial assessment within twenty-four (24) hours of the meeting with the youth and/or family to determine program eligibility, to include the review of the ADMH approved Referral Form.

2. Complete or review current ADMH approved comprehensive home-based assessment/re-assessment tool(s) by the fourteenth (14^{th}) day of enrollment.

3. Complete or review the Crisis Stabilization & Support Plan (CS&SP) by the fourteenth (14^{th}) day of enrollment.

4. Review Intensive Home-Based Services (IHBS) and offer appropriate IHBS to the youth and family by the 30^{th} day of enrollment. When the recipient is not actively enrolled in HICC, the offer of services along with the youth and family response must be documented on the ADMH approved IHBS Referral Tracking Form.

5. Collect appropriate information from prior and concurrent treatment sources as appropriate.

6. Assess the recipients need to be evaluated by the physician.

7. Document assessments and services. If one (1) team member is absent, this shall be reflected in the assessment/ progress notes.

(v) During the Treatment Plan Formulation Phase week four (4), the IHI team shall develop the treatment plan by the thirtieth (30^{th}) day of enrollment.

(w) During the Treatment Phase weeks five (5) to ten (10) IHI team shall address treatment plan objectives via a variety of therapeutic approaches, therapeutic modalities, and other interventions.

(x) During the Generalization Phase weeks ten (10) to twelve (12), IHI team shall:

1. Continue to follow the IHI model and adjust service delivery when indicated.

2. Refer the recipient and family to appropriate follow-up services, if not already receiving, which could include care coordination, Certified Peer Specialist – Youth, Certified Peer Specialist – Parent, Therapeutic Mentoring, outpatient therapy, etc. and introduce the recipient and family to new service staff.

3. Link the recipient and family to the outpatient services and conduct transfer session to review progress and any future treatment needs/issues for the recipient and their family as appropriate.

(y) The IHI team has the option of extending services beyond the initial twelve (12) weeks through two (2) clinical extensions of up to four (4) weeks each if treatment needs are clearly indicated, with prior approval of the direct supervisor. A Treatment Plan Review/Extension shall be completed documenting the clinical reasons for the extension, signed by eligible staff and filed in recipient record. Additional extensions beyond twenty (20) weeks require completion of the prior authorization process.

Author: Division of Mental Health and Substance Use Services, ADMH
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