State of Illinois
Department of Human Services
Division of Mental Health (DHS/DMH)

Service Authorization Protocol

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SERVICE AUTHORIZATION PROTOCOL AND CRITERIA

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COLLABORATIVE AUTHORIZING STAFF

Licensed Illinois mental health professionals, acting in their role as Clinical Care Managers for the Collaborative, will review and approve authorizations that will be based on the original provider request for services. Clinical Care Managers who request additional information from providers in order to make an authorization determination shall meet the Illinois Rule 132 credentialing requirements of a Licensed Practitioner of the Healing Arts.

RESPONSE TIME FOR AUTHORIZATION REQUESTS

DHS/DMH requires the Collaborative to respond to requests for authorizations within:

- one (1) business day of receipt of a complete initial authorization request excluding holidays and weekends
- three (3) business days for a complete reauthorization request excluding holidays and weekends

SUBMISSION METHOD FOR AUTHORIZATION REQUESTS:

A provider may submit an authorization request using any of the following three methods:

- Online at: www.IllinoisMentalHealthCollaborative.com
  This process can be used if:
  1. You have an electronic version of the authorization documents you are submitting, and
  2. You have a user ID and Logon to the Provider Connect system.
- By secure fax to: 1-866-928-7177
- Telephone: 1-866-359-7953 To speak with a Clinical Care Manager to verbally review the authorization request information

PROCESS FOR REVIEWS

Authorization is required for all ACT or CST services. This includes new requests and continuing service requests. The authorization time frames and documentation requirements for requests to authorize services are based on the consumer's current authorization status.

- A complete request includes:
  - Authorization Request Form (completed in full including LOCUS or Ohio Scale scores)
  - Treatment Plan
  - Crisis Plan (adult or youth/family)

Summary of Authorization Process

COLLABORATIVE REVIEW PROCESS AT A GLANCE

The provider submits a request for authorization via one of three ways indicated earlier in this document.
The Collaborative's Clinical Care Manager will:

1. Verify provider's participation status (e.g. contract with DHS/DMH, certified to provide service)
2. Verify consumer's information is in ROCS and available to the Collaborative. If not, the Collaborative will call the provider to gather demographics. The Collaborative's eligibility system will be updated on a weekly basis. If the provider is aware that the consumer has been added to the ROCS system in the preceding 5 to 7 days, it is recommended that the provider submit the demographic information to the Collaborative as a part of the request for authorization documents. This will prevent the need to call the provider to collect the demographic information.
    a. Demographic information required to create temporary eligibility in the Collaborative Care Connect system includes:
        i. First and Last name
        ii. Date of Birth
        iii. RIN number
        iv. Address
        v. Gender
        vi. Ethnicity
3. Review request for authorization information for completeness (documents required based on request type)
    a. If all three documents are present:
        i. Within 1 business day, the Collaborative's Clinical Care Manager reviews content for clinical appropriateness and informs Provider regarding outcome.
        ii. If medical necessity is established, request is authorized and communicated to provider via secure email.
        iii. If medical necessity is not established, the Clinical Care Manager contacts provider to seek clarification and offer education/consultation regarding authorization criteria.
            1. The Collaborative and the Provider will reach mutual agreement with respect to next steps (e.g. additional information will be submitted for review, alternative service will be considered, etc).
            2. If mutual agreement has not occurred and provider believes medical necessity is present, the Clinical Care Manager will forward information to the Collaborative's physician reviewer.
                a) Physician reviews request and authorizes or denies authorization

b. If all three documents are not present:
    i. The Clinical Care Manager will contact the provider and identify and request missing information. The Collaborative's required response time is suspended.
    ii. Once the complete request for authorization information is received by the Collaborative the review process will be re-initiated and the timeline starts again.

Appeals

CLINICAL APPEAL PROCESS

Prior to a denial, the Collaborative staff will phone the provider to seek clarification and offer consultation and/or education and, as necessary, discuss alternative services that may meet the consumer's needs. A denial will only be made by a board certified psychiatrist licensed in the State of Illinois. If the requested service is not authorized, a letter will be mailed to the requesting provider.

1. If the provider, consumer, or designated representative disagrees with the clinical decision, an appeal may be initiated in writing or by phone.
2. There are two levels of appeals:
    - The first level of appeal must be requested within 30 days after the denial and will be reviewed directly by the Collaborative's Medical Director who will not be the same physician nor be a subordinate of the physician who issued the original denial. The appeal will result in either a reversal of the denial decision or in upholding the denial decision. The appeal review and notification by phone will be completed by the Collaborative within 72 hours of the receipt of the appeal.
    - If the provider, consumer, or designated representative disagrees with the outcome of the first appeal, a second level appeal may be filed within 30 days of receipt of the outcome of the first appeal. This second level of appeal will be reviewed by a physician contracted only for this purpose and not otherwise employed by the Collaborative. The physician contracted for the second level review shall not receive increased compensation based on the outcome of the appeal. The second level appeal review and notification by phone will be completed by the Collaborative within 30 days of the receipt of the second level appeal.
3. Should the appealing party disagree with the outcome of the second level of appeal, a DHS/DMH Director's (or designee) administrative review may be requested within 30 days of the denial. This review shall not be a clinical review but rather shall review to ensure that all applicable appeal procedures have been correctly applied and followed. This level shall be considered a terminal or final level of review and no other review option is available. The request for an administrative review must be submitted in writing to the Director of the DHS Division of Mental Health by the appealing party. The Division will respond within 30 days of the request for the administrative review.

If the consumer is in care at the time of the appeal, the Collaborative will continue to authorize the service while the appeal is pending until:
1. the appeal is withdrawn or

2. fifteen (15) days transpires after the appeal was upheld, allowing for transition to other services.

TEAM BASED SERVICES
Assertive Community Treatment (ACT)

SERVICE DEFINITION

Assertive Community Treatment (ACT) is provided by an interdisciplinary team that ensures service availability 24 hours a day, seven (7) days a week and is prepared to carry out a full range of treatment functions wherever and whenever needed. An individual is referred to the ACT team service when it has been determined that his/her needs are so pervasive and/or unpredictable that it is unlikely that they can be met effectively by other combinations of available community services, or in circumstances where other levels of outpatient care have not been successful to sustain stability in the community. Typically this service should be targeted to individuals who have serious and persistent mental illness or co-occurring disorders, multiple diagnoses, and the most complex and expensive treatment needs.
The service objectives are addressed by activities designed to:

- promote symptom stability and appropriate use of medication;
- restore personal, community living and social skills;
- address and treat substance abuse issues;
- promote physical health;
- establish access to entitlements, housing, work and social opportunities; and
- promote the highest possible level of functioning in the community.

This team approach involves structured face-to-face in vivo therapeutic interventions to provide support and guidance in all areas of functional domains: adaptive, communication, personal care, domestic, substance abuse, psychosocial, problem solving, etc. in preventing, overcoming, or managing the individual's level of functioning and enhancing his/her ability to remain in the community.

This service includes interventions that address the functional problems associated with the most complex and/or pervasive conditions of the identified population. These interventions are strength based and focused on promoting symptom stability, increasing the individual's ability to cope and relate to others and enhancing the highest level of functioning in the community.

ACT provides ongoing assertive outreach and treatment necessary to address individual's needs effectively. This model is primarily a mobile unit, but can include some clinic-based services.

The ACT team shall have the capacity to provide a minimum of three contacts a week with consumers experiencing severe symptoms, trying a new medication, experiencing a health problem or serious life event, trying to go back to school or starting a new job, making changes in living situation or employment or having significant ongoing problems in daily living. These

multiple contacts may be as frequent as two to three times per day, seven days per week and depend on individual need and a mutually agreed upon plan between the individual and ACT staff. Staff shall share responsibility for addressing the needs of all consumers requiring frequent contact. The ACT team shall provide a minimum three contacts per week for most consumers and all consumers shall receive a minimum of four (4) face-to-face contacts per month.

Source of Funding
Funding is provided by contract by Medicaid and non-Medicaid sources.

Modality/Location
The modality and location of services can be any of the following:

- onsite and offsite;
- face to face, telephone, video conference; and/or
- individual and limited amounts of group.

Included Activities and Interventions

1. Every ACT service must be provided exclusively by the ACT team.
2. The assessment must be completed within 30 days of entry into ACT with a reassessment completed annually. The goal of the ACT team assessment is to discover those factors which led to the failure of prior treatment attempts. Each part of the comprehensive assessment area shall be completed by an ACT team member with skill and knowledge in the area being assessed. The assessment is based upon all available information, including from individual interview/self-report, family members and other significant parties, and written summaries from other agencies, including police, courts, and outpatient/inpatient facilities, where applicable. A comprehensive assessment shall be initiated and completed within 30 days after an individual's admission according to the following requirements:
    a. In collaboration with the individual, the ACT team will complete a psychiatric and social functioning history time line.
    b. In collaboration with the individual, the comprehensive assessment shall include an evaluation in the following areas:
        i. Identifying information: name, gender, date of birth, primary method of communication;
        ii. Extent, nature, and severity of presenting problems;
        iii. DSM-IV or ICD-9-CM diagnosis;
        iv. Family history, including the history of mental illness in the family;
        v. Mental status evaluation, including, at a minimum, attention, memory, information, attitudes, perceptual disturbances, thought content, speech, affect, suicidal or homicidal ideation, and an estimation of the ability and willingness to participate in treatment;
        vi. Client preferences relating to services and desired treatment outcomes;
        vii. Personal history, including mental illness and mental health treatment;
        viii. History of abuse/trauma (childhood sexual or physical abuse, intimate partner violence, sexual assault or other forms of interpersonal violence);
        ix. Present level of functioning, including social adjustment and daily living skills;
        x. Legal history and status, including guardianship and current court involvement;

xi. Assessment of risk, including the identification of factors which may endanger either the client or the client's family and other immediate threats to the client's personal safety (e.g., gang involvement, domestic violence, elder abuse);
xii. Education, specialized training, and vocational skills;
xiii. Employment history;
xiv. Interests, activities and hobbies;
xv. History of current alcohol or other substance use, abuse or dependence;
xvi. Name and contact information of the client's primary care physician;
xvii. Previous and current psychotropic medications, including date of most recent psychiatric evaluation;
xviii. General physical health, including date of last physical examination, any known symptoms or complaints, and current medications including over-the-counter medications;
xix. Resources such as family, community, living arrangements, religion, and personal client strengths; and
xx. Summary analysis, conclusions and recommendations for specific mental health services.

c. Team based Assessment Process
   i. Psychiatric History, Mental Status, and Diagnosis: The psychiatrist is responsible for completing the psychiatric history, mental status, and diagnosis assessment. Using information derived from the evaluation, an LPHA shall make an accurate diagnosis from those listed in the American Psychiatric Association's DSM IV.
   ii. Physical Health: A registered nurse (or LPN if agency meets grandfathering clause) is responsible for completing the physical health assessment.
   iii. Use of Drugs and Alcohol: A team member with experience and training in dual diagnosis substance abuse assessment and treatment is responsible for completing the use of drugs and alcohol assessment.
   iv. Education and Employment: A team member with experience and training in vocational assessment and services is responsible for completing the education and employment assessment.
   v. Social Development and Functioning: A team member who is interested and skillful in attainment and restoration of social/interpersonal skills and relationships and who is knowledgeable about human development is responsible for completing the social development and functioning assessment
   vi. Activities of Daily Living (ADL): Staff members with training to do the assessment and who have interest in and compassion for clients in this area may complete the ADL assessment.
   vii. Family Structure and Relationships: Members of the ACT team are responsible to carry out the family structure and relationships assessment.

d. An admission note may be used to initiate services prior to the completion of a mental health assessment for a client who is admitted to ACT. An admission note must be completed within 24 hours after a client's admission and is effective for a maximum of 30 days. The admission note is a written report of an initial assessment and treatment plan and shall include the following:
   i. Identifying information: name, gender, date of birth, primary language or method of communication, date of initiating assessment;

ii. Client's current mental health functioning level;
iii. Provisional diagnosis;
iv. Pertinent history;
v. Precautions (e.g., suicidal risk, homicidal risk, flight risk) and special programming to meet the client's needs;
vi. Initial treatment plan, including a list of Part 132 services that will be provided and the staff responsible for those services; and
vii. Other relevant information.

An admission note shall be completed by at least an MHP following a face-to-face or video conference meeting with the client. A QMHP shall be responsible for approving the completed admission note as documented by the QMHP's dated signature on the admission note.

3. Individualized treatment and recovery planning.
4. Peer Support Services: Services to validate individual's experiences and to guide and encourage them to take responsibility for and actively participate in their own recovery. In addition, services to help individuals identify, understand, and combat stigma and discrimination against mental illness and develop strategies to reduce self-imposed stigma:
   a. peer counseling and support, and
   b. introduction and referral to self-help programs and advocacy organizations that promote recovery.
5. Service Coordination: Each individual will be assigned a primary service coordinator who coordinates and monitors the activities of the ACT team. Other staff of the ACT team shares these tasks with the service coordinator and are responsible to perform the tasks when the service coordinator is not working. Responsibilities can include:
   a. working with the individual to write the treatment plan,
   b. providing individual supportive counseling,
   c. offering options and choices in the treatment plan,
   d. ensuring that immediate changes are made as the individual's needs change,
   e. advocating for the wishes, rights, and preferences,
   f. serving as the primary point of contact when the individual is in crisis,
   g. serving as the primary support person and educator to the individual's family, and
   h. coordinating with community resources, including self-help and advocacy organizations that promote recovery.
6. Crisis Assessment and Intervention Services: Crisis assessment and intervention shall be provided by the team 24 hours a day, seven (7) days a week. These services will include telephone and face-to-face contact.
7. Symptom Assessment and Management: This shall include but is not limited to the following:
   a. Ongoing comprehensive assessment of the individual's mental health symptoms, accurate diagnosis, and the individual's response to treatment.
   b. Psychoeducation regarding mental illness and the effects and side effects of prescribed medications.
   c. Symptom management efforts directed to help each individual identify/target the symptoms and occurrence patterns of his/her mental illness and develop methods (internal, behavioral, or adaptive) to help lessen the effects.

8. Supportive counseling and psychotherapy, including generous psychological support to consumers, both on a planned and as-needed basis, to help them accomplish their personal goals, to cope with the stressors of day-to-day living, and to recover.
9. Medication prescription, administration, monitoring, and documentation:
    a. The ACT team Psychiatrist shall:
        i. establish a clinical relationship with each individual,
        ii. assess each individual's mental illness symptoms and provide verbal and written information about mental illness,
        iii. make an accurate diagnosis based on the comprehensive assessment,
        iv. provide education about medication, benefits and risks, and obtain informed consent, and
        v. assess and document the individual's mental health symptoms and behavior in response to medication and monitor and document medication side effects.
    b. All ACT team members shall assess and document the individual's mental health symptoms and behavior in response to medication and shall monitor for medication side effects.
10. Co-occurring substance abuse services, including:
    a. Provision of a stage-based treatment model that is non-confrontational, considers interactions of mental illness and substance abuse, and has individual-determined goals. This shall include but is not limited to individual interventions in:
        i. engagement (e.g., empathy, reflective listening, avoiding argumentation);
        ii. assessment (e.g., stage of readiness to change, client-determined problem identification);
        iii. motivational enhancement (e.g., developing discrepancies; psychoeducation);
        iv. active treatment (e.g., cognitive skills training, community reinforcement); and
        v. continuous relapse prevention (e.g., trigger identification, building relapse prevention action plans).
11. Work and education related services: Work and education related services to help individuals value, find and achieve meaningful employment or education in community-based job and education sites including but not necessarily limited to:
    a. Mental Health Services that support work and education related recovery goals (billed to Medicaid)
        i. Skill building activities that focus on the development of skills to be used by clients in their living, learning, social and working environments, which may include:
            a) Socialization, communication, adaptation, problem solving and coping;
            b) Self-management of symptoms or recovery;
            c) Concentration, endurance, attention, direction following, planning and organization; and
            d) Establishing or modifying habits and routines;
        ii. Assessment of the effect of the individual's mental illness on education and employment with identification of specific behaviors that interfere with the individual's school and/or work performance and development of interventions to reduce or eliminate those behaviors and find effective accommodations.

iii. Individual supportive counseling/therapy to help the person identify and cope with mental illness symptoms that may interfere with their work or school performance.
iv. On-the-job, at-school, or work/school-related crisis intervention.

b. Work and education related services (not billed to Medicaid, but included as part of the ACT team function).
i. Talking about past and current and future employment goals, going to various work sites to explore the world of work, and assisting client in identifying the pros and cons of working.
ii. Assessment of job-related interests and abilities through a complete education and work history assessment as well as on-the-job assessments in community-based jobs.
iii. Development of an ongoing educational and employment rehabilitation plan to help each individual establish job specific skills and credentials necessary to achieve ongoing employment.
iv. Work/school-specific supportive services, such as assistance with securing of appropriate clothing, wake-up calls, addressing transportation issues, etc.
v. Job-specific supports such as teaching/coaching a job task, helping identify the pros and cons of disclosure or visiting the client at the job site to identify and address issues pertinent to job retention.

12. Activities of Daily Living: Services to support activities of daily living in community-based settings include individualized assessment, problem solving, sufficient side-by-side assistance and support, skill training, ongoing supervision (e.g. prompts, assignments, monitoring, encouragement), and environmental adaptations to assist consumers gain or use the skills required to:
a. find housing that is safe, of good quality, and affordable (e.g., apartment hunting; finding a roommate); landlord negotiations; cleaning, furnishing, and decorating; and procuring necessities such as telephones, furnishings, linens;
b. perform household activities, including house cleaning, cooking, grocery shopping, and laundry;
c. carry out personal hygiene and grooming tasks, as needed;
d. develop or improve money-management skills;
e. use available transportation; and
f. have and effectively use a personal physician and dentist.
13. Social/Interpersonal Relationship and Leisure Time Skill Building: Services to support social/interpersonal relationships and leisure-time skill training (e.g., problem solving, role-playing, modeling, and support); social-skill teaching and assertiveness training; planning, structuring, and prompting of social and leisure-time activities; side-by-side support and coaching; and organizing individual and group social and recreational activities to structure consumer's time, increase their social experiences, and provide them with opportunities to practice social skills and receive feedback and support required to:
a. improve communication skills, develop assertiveness, and increase self-esteem;
b. develop social skills, increase social experiences, and develop meaningful personal relationships;
c. plan appropriate and productive use of leisure time;
d. relate to landlords, neighbors, and others effectively; and

e. familiarize themselves with available social and recreational opportunities in natural settings and increase their use of such opportunities.

14. Environmental and other Support Services: Support services or direct assistance to ensure that individuals obtain the basic necessities of daily life, including but not necessarily limited to:
    a. medical and dental services;
    b. safe, clean, affordable housing;
    c. financial support and/or benefits counseling (e.g., SSI, SSDI, Food Stamps, Section 8, Vocational Rehabilitation, Home Energy Assistance)
    d. social services;
    e. transportation; and
    f. legal advocacy and representation.
15. Services provided regularly to consumers' families and other major supports, with individual agreement or consent, include:
    a. psychoeducation about the individual's illness and the role of the family and other significant people in the therapeutic process;
    b. intervention to restore contact, resolve conflict, and achieve stable relationships with family and or other significant people;
    c. ongoing communication and collaboration, face-to-face and by telephone, between the ACT team and the family; and
    d. introduction and referral to family self-help programs and advocacy organizations that promote recovery.

Service Requirements

1. Services must be available 24 hours a day, seven (7) days a week with emergency response coverage, including psychiatric coverage. Crisis services shall be provided 24 hours a day, seven (7) days a week by the ACT team assigned to the individual.
2. The following minimal contact standards apply:
    a. A minimum of 75 percent of all team contacts (aggregate) shall occur in a natural setting.
    b. A minimum of three contacts per week is provided for most consumers.
    c. A minimum of four contacts per month is provided to all consumers.
3. Unplanned dropouts and involuntary closures are minimal (less than 10 percent). Team is persistent in engagement (i.e., at least two (2) face-to-face attempted contacts per week), continuing attempts for consumers who refuse services for a minimum of three (3) months.
4. The ACT team shall conduct organizational staff meetings at regularly scheduled times per a schedule established by the team leader. These meetings are attended by all team members assigned to be on duty with the exception of the psychiatrist(s) who should attend at a minimum of three (3) meetings per week. Meetings will review the status of all individuals via daily log, and develop a daily staff assignment schedule.
5. Services may be delivered by a single team member to two consumers at the same time if their goals are compatible; however this cannot be standard practice.
6. The only scenario in which ACT may be offered to more than two consumers is when a curriculum-based therapeutic group is offered such as DBT. For this to be allowable there must be an identified cohort of ACT participants whose clinical needs and recovery goals justify intervention by staff trained in the implementation of the specific curriculum-based milieu. This group may be offered to no more than eight ACT participants at one time and

must be directed by no fewer than two staff in order to be billed as ACT. This may be offered no more than two (2) hours in any given week.

7. The ACT team program shall establish medication policies and procedures which identify processes to:
   a. record physician orders;
   b. order medication;
   c. arrange for all individual medications to be organized by the team and integrated into consumers' weekly schedules and daily staff assignment schedules;
   d. provide security for medications (e.g., daily and longer-term supplies and long-term injectibles) and set aside a private designated area for set up of medications by the team's nursing staff; and
   e. administer medications per state law to clients.

Staffing Requirements

The minimum size for an ACT team is at least six (6) full time staff excluding the psychiatrist and program assistant. All teams are required to have, at a minimum:

1. Full time team leader who is the clinical and administrative supervisor of the team and who also functions as an ACT clinician. The team leader shall be a licensed clinician.
2. A psychiatrist who works on a full or part time basis for a minimum of 10 hours per week for every 60 consumers. The psychiatrist must provide clinical and crisis services to all team members, work with the team leader to monitor each individual's clinical and medical status and response to treatment, and direct psychopharmacologic and medical treatment. With a certification waiver, an Advanced Practice Nurse may substitute for up to half of the psychiatrist time.
3. A full time registered nurse who provides services to all ACT consumers and who works with the ACT team to monitor each individual's clinical status and response to treatment. The registered nurse functions as a primary practitioner on each ACT team for a caseload of consumers. Existing ACT providers may use an LPN with two years experience in mental health services as part of an ACT team until July 1, 2009. New ACT providers shall be required to utilize an RN on all ACT teams.
4. Four staff who work under the supervision of a licensed clinician and function as primary practitioners for a caseload of consumers and who provide rehabilitation and support functions;
5. A program/administrative assistant who is responsible for organizing, coordinating, and monitoring all non-clinical operations of ACT, including managing medical records; operating and coordinating the management information system; maintaining accounting and budget records for individual and program expenditures; and providing receptionist activities, including triaging calls and coordinating communication between the team and individual.
6. At least one of the members of the core team must have special training and certification in substance abuse treatment and/or treating persons with co-occurring disorders.
7. At least one member of the team should be an individual in recovery and, if available, be credentialed as a Certified Recovery Support Specialist. This staff person is a fully integrated ACT team member who provides consultation to the ACT team, highly individualized services in the community, and who promotes self-determination and decision making.

8. At least one member of the core team must have special training in rehabilitation counseling, especially vocational, work readiness, and educational support.
9. Each team is expected to maintain a staff to individual ratio of no more than one (1) staff person per 10 consumers (excluding the psychiatrist and program assistant). As the number of consumers increase, teams must add staff to maintain this ratio.
10. Each team is expected to reflect the language, culture, and ethnicity of the population being served.

Service Exclusions
ACT may not be billed in combination with other Rule 132 services, with the exception that preapproved services may be billed on an individual basis and in accordance with a treatment plan in order to facilitate transition to and from the ACT service. This allowable transition time will be subject to public payer prior authorization and will be limited to 30 days.

Documentation Requirements
All documentation will be prepared and delivered in accordance with the requirements of Rule 132. In addition**:**

1. The ACT team shall conduct daily organizational staff meetings at regularly scheduled times per a schedule established by the team leader. The ACT team shall maintain a written daily log, using either a notebook, cardex, MIS system database. The daily log will provide a roster of the clients served in the program, and for each client, a brief documentation of any treatment or service contacts that have occurred during the last 24 hours and a concise, behavioral description of the client's status that day.
2. The ACT team shall maintain and review as a part of the treatment planning and review process a consumer developed Crisis Plan.

Admission Criteria
DHS/DMH or its designee shall authorize ACT services for eligible consumers who meet the following criteria:

Eligible Population
Adults (age 18 or older) affected by a serious mental illness requiring assertive outreach and support in order to remain connected with necessary mental health and support services and to achieve stable community living. The program is inclusive of young adults who have met criteria for ICG if they meet other conditions listed below. Priority is given to persons affected by schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder because these illnesses more often cause long-term psychiatric disability. Consumers with other major psychiatric disorders may be eligible when other services have not been effective in meeting their needs. Eligible persons will be affected by one of the following diagnosis:

1. Schizophrenia (295.xx)
2. Schizophreniform Disorder (295.4x)
3. Schizo-Affective Disorder (295.7)
4. Delusional Disorder (297.1)
5. Shared Psychotic Disorder (297.3)
6. Brief Psychotic Disorder (298.8)
7. Psychotic Disorder NOS (298.9)

8. Bipolar Disorder (296.xx; 296.4x; 296.5x; 296.7; 296.8; 296.89; 296.9)

Symptom and Functional Indicators

1. Additionally the person must be someone for whom traditional services and modes of delivery have not been effective, and the individual should have one or more of the following problems that are indicators of a need for continuous high level of services (i.e., greater than eight hours per month):
   a. Two or more psychiatric inpatient readmissions over a 12 month period or one long- term hospitalization of 180 days or more (Source: NAMI PACT Criteria)
   b. Excessive use (2 or more visits in a 30 day period) of crisis/emergency services with failed linkages.
   c. Chronic homelessness
   d. Repeat (2 or more in a 90 day period) arrests and incarceration for offenses related to mental illness such as trespassing, vagrancy or other minor offenses.
   e. Consumers with multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers.
   f. Consumers who exhibit continuous functional deficits in achieving treatment continuity, self-management of prescription medication, or independent community living skills.
   g. Consumers with persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate.
2. The person must be someone with significant impairments as a result of their mental illness. Typically the consumer has a LOCUS composite score of 4 and above as scored prior to admission into the ACT program.
3. Consumers with significant functional impairments as demonstrated by at least one of the following conditions:
   a. Significant difficulty consistently performing the range of practical daily living tasks required for basic adult functioning in the community (e.g., caring for personal business affairs; obtaining medical, legal, and housing services; recognizing and avoiding common dangers or hazards to self and possessions; meeting nutritional needs; achieving good personal hygiene) or persistent or recurrent difficulty performing daily living tasks except with significant support or assistance from others such as friends, family, or relatives.
   b. Significant difficulty achieving consistent employment at a self-sustaining level or significant difficulty consistently carrying out the homemaker role (e.g., household meal preparation, washing clothes, budgeting, or child care tasks and responsibilities) or of achieving consistent educational placement (depending on developmental level).
   c. Significant difficulty achieving a safe living situation (e.g., repeated evictions or loss of housing).

   Priority is given to people with schizophrenia, other psychotic disorders (e.g., schizoaffective disorder), and bipolar disorder.

   Exceptions to these criteria may be submitted for authorization consideration but will require additional clinical documentation and justification from the provider.

Continued Stay Service Criteria

The following criteria are necessary for continuing treatment with ACT services:

1. The person's severity of illness and resulting impairment continues to require ACT.

2. Services are consistent with the person's recovery goals and are focused on reintegration of the individual into the community and improving his/her functioning in order to reduce unnecessary utilization of more intensive treatment alternatives (e.g., residential or inpatient).
3. The mode, intensity, and frequency of treatment are appropriate.
4. Active treatment is occurring and continued progress toward goals is anticipated.
5. Treatment planning is individualized and appropriate to the individual's changing condition, and include the following as appropriate to stabilize and improve functioning:
   a. outreach (e.g., linkage with community agencies, educational presentations);
   b. assistance and referral with meeting basic needs (e.g., housing, food, medical care);
   c. psychosocial evaluation and treatment;
   d. crisis intervention;
   e. social rehabilitation;
   f. individual and family support and education (e.g., symptom management);
   g. coordination and development of alternative support systems (e.g., religious organizations, self-help groups, peer support);
   h. protection and advocacy resources;
   i. coordination of services, including vocational, medical, and educational needs; and
   j. medication and treatment monitoring.
6. The services listed in *5 a-j* are provided as needed and agreed upon in the treatment plan by providers and the individual.
7. The individual continues to require services in order to maximize functioning and sustain recovery or the individual's support network (e.g., family, friends, and peers) is insufficient to allow for independent living. (This usually is evidenced by a LOCUS composite score of 4 or above- explain variations as needed)

INITIAL (NEW) ACT AUTHORIZATION PROCESS

To request an authorization for a consumer who is not currently receiving ACT, the treating provider will submit a complete request for authorization of ACT packet that includes:

1. The ACT Authorization Request Form revised 1/14/08 that includes LOCUS information for adults
2. A treatment plan, including the treatment plan options of
   a. An initial treatment plan with ACT listed as a service, or
   b. A treatment recommendation from a comprehensive assessment not completed by the ACT team (This assessment and treatment recommendation can also come from a hospital facility or another community provider
3. The consumer's initial crisis plan

Once the initial ACT request is submitted, the documents will be reviewed for adherence to the clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services the Collaborative will enter an initial authorization for 90 days of services.

A LOCUS assessment needs to be completed as part of the authorization request. Typically a composite score of 4 indicates that the individual's needs are so pervasive and/or unpredictable, it is unlikely that other combinations of available community services have been or would be

effective. There is a section on the request form where the provider can explain the variance between the clinical presentation and a LOCUS score below 4. Typically the LOCUS score is updated at the time of a treatment plan review, when a consumer is discontinuing services or when the consumer's clinical condition warrants.

Providers are to complete the comprehensive team based assessment and the ACT treatment plan within the first 30 days of ACT services. Before the initial authorization expires, the ACT team is to submit a reauthorization request if the consumer continues to need ACT services. This request should be submitted within two weeks of the initial authorization expiration date.

REAUTHORIZATION PROCESS FOR ACT

To request a reauthorization for a consumer who is currently receiving ACT, the treating provider will submit a complete request for authorization of ACT packet that includes:

1. The ACT Authorization Request Form that includes LOCUS information for adults.
2. An updated ACT treatment plan based on the comprehensive assessment inclusive of specific addendums completed by the ACT team, and
3. The consumer's crisis plan.

Once the request for reauthorization of ACT services is submitted, the documents will be reviewed for adherence to clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services, the Collaborative will enter an authorization for up to 180 days of services.

If the clinical criteria are not met, the Collaborative will either authorize a 30 day transition period or the Collaborative will deny the requested service.

Before the reauthorization expires, the ACT team is to submit a reauthorization request if the consumer continues to need ACT services. This request should be submitted within two weeks prior to the current authorization expiration date.

Transition from ACT Services

When a consumer is transitioning into or out of ACT, other mental health services can be provided (in addition to ACT) when clinically indicated for a period of 30 days.

In order to facilitate reimbursement, the ACT provider must submit an updated Request for Authorization for ACT completing the Transition Plan section and indicating the additional services that are clinically indicated. These additional services should also be included on the Individualized Treatment Plan. Examples of when this may occur include:

1. Crisis Residential: When an individual requires crisis residential to avert a hospitalization, ACT services should continue in addition to the residential services. The provider should indicate the need for Community Support Residential and any other services that the client requires during the crisis residential stay.
2. Community Services: When an individual is being transitioned to an array of outpatient services (for example, PSR, Community Support, Counseling, and Medication Management). The ACT provider should indicate the specific services to which the client is being transitioned.

3. Community Support Team: When an individual is being transitioned to Community Support Team, CST should be indicated in the Transition Plan of the Request for Authorization for ACT form. In addition, a Request for Authorization for CST form must be submitted by the CST provider.

Discontinuation of ACT services:
Providers must notify the Collaborative when a consumer is discontinuing ACT services by completing a "Notification of Discontinuance of ACT Services" form and faxing it to the Collaborative or by entering the information in ProviderConnect

Discontinuance of ACT services shall occur when:

1. Person requests termination from ACT and is currently stable
2. Person has improved to the extent that ACT is no longer needed and recovery goals have been met. (No medical necessity for ACT – indicate transition plan on Notification of Discontinuance form.)
3. Person has moved out of the ACT teams' geographic area (provide linkage information to the new ACT team or community service)
4. Person has moved out of State (make attempts to link with other ACT or community services)
5. Person cannot be located, in spite of repeated ACT efforts. (Describe efforts to locate and continue ACT services such as number of failed contacts, time elapsed since last contact, lack of leads on whereabouts from the person's emergency contact list)
6. Person is deceased.

Detailed information regarding discontinuance of ACT services and linkage to other services must be documented in the consumer's clinical record.

Reasons for Medical Necessity denials of ACT services
The consumer does not evidence each of the following as described in Rule 132 and the Authorization Protocol developed by DHS/DMH:

- The individual is not affected by a diagnosis referenced in Rule 132 for this service request
- There is not evidence that the individual is someone for whom traditional services and modes of delivery have not been effective
- There is not evidence of significant impairments as a result of a mental illness supported by the LOCUS composite score
- There is not evidence of significant functional impairment

Request for Authorization of Assertive Community Treatment Services (ACT) ☐Initial Request or ☐Reauthorization Request

Fax request forms to the Collaborative: 866-928-7177

Agency: _____	**Name of Referred**: _____
Agency Location:_____	**Date of Birth**: _____
Agency FEIN:_____	**RIN #** _____
Team Name: _____	
Male: ☐ **Female:** ☐	**Date ACT service started;** _____

I. SERVICE DEFINITION CRITERIA (Please check all that apply)

☐ Multiple and frequent psychiatric inpatient admissions;

Acute Inpatient Episodes in the prior 12 months:

Facility:_____ Dates of Service_____

Facility:_____ Dates of Service_____

Facility:_____ Dates of Service_____

Current Medications:(name, dose, frequency)

☐ Excessive use of crisis/emergency services with failed linkages

☐ Chronic homelessness

☐ Repeat arrests and incarcerations

☐ Individual has multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers

☐ Individual exhibits functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills

☐ Individual has persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate

II. DIAGNOSIS

DSM Diagnosis ***All 5 Axes must be completed***	**Diagnosis (Code)**	**Rank** **(Please rank diagnoses in Axes 1-3 in order of primacy)**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF)	Highest Last Year:	Current:

Agency: _____ **Name of Referred**: _____

Date of Birth: _____ **RIN #** _____

III. FUNCTIONAL IMPAIRMENT (**Fill out all domains from the LOCUS tool)**

Domain Scores: Risk of Harm: _____ **Recovery Environment – Environmental Stressors:** _____

Recovery Environment – Environmental Support: _____ **Functional Status:** _____

Co-morbidity: _____ **Recovery and Treatment History:** _____ **Acceptance and Engagement:** _____

LOCUS RECOMMENDED LEVEL OF CARE: **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

Reason for deviation (if Applicable)
Explain:

IV. TRANSITION PLAN – If applicable (NARRATIVE) (Please write legibly.)

This section is for instances in which utilization of ACT is recommended as part of a transition plan.
Please describe the clinical need for the transition to less intensive services or more intensive service:

List additional services that are clinically indicated:

TRANSITION START DATE: TRANSITION END DATE:

Clinical staff to contact with any questions (print) _____

Phone: (_____)_____ Fax Number: (_____)_____

Encrypted email address: _____

Please attach the following to this request form:
1) The current treatment plan ☐
2) The consumer's crisis plan ☐

FOR REAUTHORIZATION REQUEST: The medical necessity for this Request for Authorization and the attached Treatment Plan is recommended by an LPHA and is based upon a completed Comprehensive Mental Health Assessment that is in the consumer's clinical record and available upon request. ☐ Yes

Please note that incomplete forms will be returned

Notification of Discontinuation from Assertive Community Treatment

Fax Forms to the Collaborative at: 866-928-7177

Agency: _____	**Name of Referred**: _____
Agency Location:_____	**Date of Birth**: _____
Agency FEIN:_____	**RIN #** _____
Team Name: _____	
Male: ☐ **Female:** ☐	
Admit Date to ACT:_____	
ACT was discontinued on(date): _____	

I. DISCONTINUANCE CRITERIA (Please check only one)

☐ Person requests termination from ACT and is currently stable (complete transition plan for ongoing services)
☐ Person has improved to the extent that ACT is no longer needed and recovery goals have been met and there is no medical necessity for ACT (complete transition plan for ongoing services)
☐ Person has moved out of the ACT teams geographic area and has been linked to the following program
☐ Person has moved out of the State and has been linked to the following services
☐ Person cannot be located, in spite of repeated ACT efforts (Describe efforts to locate and continue ACT services such as number of failed contacts, time elapsed since last contact: lack of leads on whereabouts from the person's emergency contact list.)
☐ Person requests termination from ACT despite the clinical recommendation of the team
☐ Person has been incarcerated
☐ Person is in need of hospitalization that may exceed 90 days
☐ Person is in need of nursing facility level of care that may exceed 90 days
☐ Deceased

II. DIAGNOSIS ON EXIT

DSM Diagnosis *All 5 Axes must be completed*	**Diagnosis (Code)**	**Rank (Please rank diagnoses in Axes 1-3 in order of primacy)**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF)	Highest Last Year:	Current:

Agency: _____ **Name of Referred**: _____

Date of Birth: _____ **RIN #** _____

III. LOCUS SCORE AT TIME OF DISCONTINUED SERVICE

Domain Scores: Risk of Harm: _____ **Recovery Environment – Environmental Stressors:** _____

Recovery Environment – Environmental Support: _____ **Functional Status:** _____

Co-morbidity: _____ **Recovery and Treatment History:** _____ **Acceptance and Engagement:** _____

LOCUS score recommended at of service being discontinued **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

Reason for deviation (if Applicable)
Explain:

IV. TRANSITION PLAN – If applicable (NARRATIVE) (Please write legibly.)

Clinical staff to contact with any questions (print) _____

Phone: (_____) _____ Fax Number: (_____) _____

Encrypted email address: _____

Please note that incomplete forms will be returned

TEAM BASED SERVICES
Community Support Team (CST)

Service Definition
Community Support Team is recovery and resiliency oriented, intensive, community-based rehabilitation and outreach service for adults and youth. It is team-based and consists of mental health rehabilitation interventions and supports necessary to assist the recipient in achieving and maintaining rehabilitative, resiliency and recovery goals. Community Support Team is designed to meet the educational, vocational, residential, mental health, co-occurring disorders (MH/SA, MH/DD, MH/Medical), financial, social and other treatment support needs of the recipient. Interventions are provided primarily in natural settings, and are delivered face to face, by telephone, or by video conference with individual recipients and their family/significant others as appropriate, to the primary well-being and benefit of the recipient. Community Support Team assists in the development of optimal developmentally appropriate community living skills, and in setting and attaining recipient (and family in the case of children) defined recovery/resiliency goals. It is available 24 hours per day, 7 days per week. A team-based approach to services must be documented in the clinical record, including the ITP.

Community Support Team may serve as a step down for individuals transitioning from more intensive or restrictive levels of care, or for those with psychiatric hospitalizations/repeated detoxification incidence in the past 18 months who are at risk of out of home placement. It is provided to recipients to decrease hospitalizations and crisis episodes and increase community tenure/independent functioning; increase time working, in school or with social contacts; and personal satisfaction and autonomy. Community support team may also serve as a step up from less intensive levels of care when those interventions have not succeeded in meeting the individual's clinical and rehabilitative needs. Through clinical interventions and supports based on identified, individualized needs, the recipient will reside in independent, semi-independent, or family living arrangements and be engaged in the recovery/treatment process. The purpose/intent of Community Support Team is to provide specific, measurable, and individualized mental health rehabilitation interventions to each person served through the reduction and management of symptoms and the development of stability and independence.

Source of Funding
Medicaid and non-Medicaid sources

Modality/Location
The modality and location of services can be any of the following:
- onsite and offsite;
- face to face, telephone, video conference; and/or
- individual and limited amounts of group.

Included Activities and Interventions
1. Promotion of the individual's active participation in decision making and self advocacy in all aspects of services and recovery.

2. Support for recovery and resilience activities, including assisting the individual to identify strengths, which may assist in recovery/resiliency and how to use them; and identification of barriers to recovery/resiliency and how to overcome them.
3. Assistance in developing strategies and supportive interventions for achieving placement in the least restrictive setting.
4. Assistance in building and maximizing family/significant other support skills. Such assistance must primarily be for the well-being and benefit of the individual.
5. Encouraging the identification of existing natural supports and the development and eventual succession of natural supports in all aspects of life. Assisting the individual to build a natural support team for treatment and recovery.
6. Education, training and assistance in the development of the individual's strengths, resources, preferences, and choices including such examples as the development of crisis contingency and Wellness Recovery and Action Plans (WRAP plans) .
7. In conjunction with the individual, family / significant other (if applicable) identification of risk factors related to relapse in mental health and/or co-occurring disorders, and development of strategies and plans to prevent relapse.
8. Assistance in the development of interpersonal, family and community coping, and functional skills (including adaptation to home, school, family and work environments) when the acquisition of those skills is impacted negatively by the individual's mental illness. Examples of skills include:
    a. Socialization skills:
        i. communication;
        ii. interpersonal relationships, including those with peers, family, authority figures, and within the community;
        iii. problem solving/conflict resolution;
        iv. management of sensory input and stress.
    b. Natural support system development:
        i. Self-directed engagement in community social activities (e.g. development of a social-recreational plan with the individual).
    c. Adaptation skills:
        i. identification of behaviors that interfere with performance;
        ii. implementation of interventions to alleviate problem behavior, including coping with symptoms of mental illness that affect the person's ability to successfully work, attend school and/or undertake family and community roles;
        iii. decrease at-risk behaviors;
        iv. development of capacity to follow directions and carry out assignments;
        v. acquisition of appropriate school and/or work habits.
    d. Adaptation to community, environment and/or family circumstances and realities.
    e. Family education, training and support designed to develop the family as a parenting and support system to the individual. Such activities must be directed toward the primary well-being and benefit of the individual.
    f. Skills related to developmental issues including:
        i. physical changes;
        ii. emotional changes;
        iii. sexuality;
        iv. social development.

g. Daily living skills including:
    i. age and developmentally appropriate daily and community living skills;
    ii. personal hygiene and grooming;
    iii. nutritional education;
    iv. food planning, grocery shopping, cooking, and eating;
    v. household maintenance, including housecleaning and laundry;
    vi. money management and budgeting;
    vii. shopping for daily-living necessities;
    viii. community awareness and current events;
    ix. identification and use of social and recreational skills;
    x. use of available transportation;
    xi. personal responsibility.

h. Work readiness activities (excepting skills related to a specific vocation, trade, or practice) including:
    i. work-related social and communication skills;
    ii. work-related personal hygiene and dress;
    iii. work-related time management;
    iv. other related skills preparing the recipient to be employable.

9. Counseling and intervention including but not limited to:
    a. motivational interviewing;
    b. stage-based interventions;
    c. refusal skill development;
    d. cognitive behavioral therapy;
    e. psychoeducational approaches.
10. Development and support of skills used for coping with trauma issues.
11. Assisting the individual in symptom self-monitoring, reduction, and management to improve quality of life and to identify and minimize the negative effects of the mental illness and co-occurring disorders, which interfere with his/her ability to succeed within community, home, school, and work settings.
12. Support and consultation to individual's family and their support systems. Interventions must be directed primarily to the well-being and benefit of the individual.
13. Psychoeducation, counseling and skill building for individual's family and their support systems, when those interventions are directed primarily to the well-being and benefit of the individual, with or without the client being present. In all cases, the family or support system psychoeducation or skill building must relate to a need identified in the assessment and be reflected on the ITP.

Service Requirements

1. Community Support Team is provided to individuals or their family members (or significant natural support persons) and may be provided face-to-face, by telephone, and by videoconference.
2. A minimum of 60 percent of all Community Support Team interventions must be delivered in natural settings and out of the provider's office(s). This requirement will be monitored in aggregate for an agency for an identified billing period but will not be required for each individual.

3. Community Support Team occurs during times and at locations that reasonably accommodate the individual's and family's needs in community locations and other natural settings and at hours that do not interfere with his/her work, educational, and other community activities.
4. Community Support Team maintains a client-to-staff ratio of no more than 18 consumers per staff member. Client-to-staff ratio takes into consideration evening, weekend and holiday hours, needs of special populations, and geographical areas to be served.
5. Documentation must demonstrate that more than one member of the team is actively engaged in the direct service to each individual.

Staffing Requirements
Minimum staffing requirements for a Community Support Team include the following:

1. Fulltime Team Leader who is the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team; this individual must be a QMHP or LPHA.
2. RSAs or MHPs who work under the supervision of the QMHP and who work on the team in sufficient fulltime equivalents to meet the required client-to-staff ratio.
3. At least one member of the team shall be an individual in recovery from mental illness preferably a Certified Recovery Support Specialist (CRSS) or a Family Resource Developer (FRD). This staff person is a fully integrated CST team member who provides consultation to the team and highly individualized services in the community, and who promotes self-determination and decision making.
4. Each Community Support Team must be comprised of no fewer than 3 FTE staff meeting the required team components (shall include the team leader) and no more than 6 FTE staff or 8 different staff.

Documentation Requirements
1. All documentation will be prepared and delivered in accordance with the requirements of Rule 132.
2. Demonstrate evidence of more than one team member directly providing services to each individual.
3. Document in the assessment or elsewhere that the individual meets the specific admission criteria below.
4. The CST team shall conduct team meetings no less than once per week and maintain a written log.
5. The CST team shall maintain and review as a part of the treatment planning and review process a consumer developed Crisis Plan. If the consumer is a child, then the crisis plan should be developed with the child and family.

Service Exclusions
CST may not be billed in combination with CSI, CSR or ACT with the exception of preapproved services that may be billed on an individual basis and in accordance with a treatment plan in order to facilitate transition to and from CST. This allowable transition time will be subject to public payer prior authorization and will be limited to 30 days.

Admission Criteria
DHS/DMH or designee shall authorize CST services for eligible consumers who meet the following criteria:

Eligible Population
Community Support Team services are intended for adults, adolescents and children whose mental health needs require active team-based therapeutic and rehabilitative assistance and support to function at a developmentally appropriate level within home, community, work, and/or school settings. This includes those whose mental illness requires a team based outreach and support for their moderate to severe mental health symptoms, and who, with such coordinated clinical and rehabilitative support, may access and benefit from a traditional array of psychiatric services, a less intensive service intensity has been tried and failed or considered and found inappropriate at this time, AND who exhibit three (3) or more of the following:

1. Multiple and frequent psychiatric inpatient readmissions, including long term hospitalization;
2. Excessive use of crisis/emergency services with failed linkages;
3. Chronic homelessness;
4. Repeat arrest and incarceration;
5. History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing;
6. High use of detoxification services (e.g., two or more episodes per year);
7. Medication resistant due to intolerable side effects or their illness interferes with consistent self-management of medications;
8. Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated clinical and supportive interventions;
9. Because of behavioral health issues, the child or adolescent has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent;
10. Clinical evidence of suicidal ideation or gesture in last three (3) months;
11. Ongoing inappropriate public behavior within the last three months including such examples as public intoxication, indecency, disturbing the peace, delinquent behavior;
12. Self harm or threats of harm to others within the last three (3) months;
13. Evidence of significant complications such as cognitive impairment, behavioral problem or medical problems.

Exceptions to these criteria may be submitted for authorization consideration but will require additional clinical documentation and justification from the provider.

Symptom and Functional Indicators
The person must be someone for whom traditional services and modes of delivery have not been effective, and the individual should have one or more of the following problems, which are indicators of a need for continuous high level of services (i.e., greater than eight hours per month):
1. Two or more psychiatric inpatient readmissions over a 12 month period or one long term hospitalization of 180 days or more (Source: NAMI PACT Criteria);

2. Excessive use (2 or more visits in a 30 day period) of crisis/emergency services with failed linkages;
3. Chronic homelessness (HUD Definition of Homelessness);
4. Repeat (2 or more in a 90 day period) arrests and incarceration for offenses related to mental illness such as trespassing, vagrancy or other minor offenses;
5. Consumers with multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers;
6. Consumers who exhibit continuous functional deficits in achieving treatment continuity, self-management of prescription medication, or independent community living skills;
7. Consumers with persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or a high relapse rate;
8. Adult consumers with significant impairments as a result of his/her mental illness with a LOCUS composite score of 4 and above. Consumers who are youth exhibit scores of at least a score of 37 for problem severity on the worker's form of the Ohio Youth Problems, Functioning, and Satisfaction Scales (hereafter referred to as Ohio Scales).

Continued Stay Services Criteria
The following criteria are necessary for continuing treatment with CST services:

1. The person's severity of illness and resulting impairment continues to require CST
2. Services are consistent with the person's recovery goals, and for youth the family's, and are focused on reintegration of the individual into the community and improving his/her functioning in order to reduce unnecessary utilization of more intensive treatment alternatives (e.g., residential or inpatient)
3. The mode, intensity, and frequency of treatment is appropriate
4. Active treatment is occurring and continued progress toward goals is anticipated
5. Treatment planning is individualized and appropriate to the individual's changing condition, and includes the following as appropriate to stabilize and improve functioning:
   a. outreach (e.g., linkage with community agencies, educational presentations);
   b. assistance and referral with meeting basic needs (e.g., housing, food, medical care);
   c. psychosocial evaluation and treatment;
   d. crisis intervention;
   e. social rehabilitation;
   f. individual and family support, training, counseling and education, (e.g., symptom management);
   g. coordination and development of alternative support systems (e.g., religious organizations, self-help groups, peer support);
   h. protection and advocacy resources;
   i. coordination of services, including vocational, medical, and educational needs;
   j. medication and treatment monitoring.

The services listed in *5 a-j* are provided as needed and agreed upon in the treatment plan by providers and the individual, and for youth, the family.

The individual continues to require services in order to maximize functioning and sustain recovery or individual's support network (e.g., family, friends, and peers) is insufficient to allow for independent, or age appropriate living.

INITIAL (NEW) CST AUTHORIZATION PROCESS

To request an authorization for a consumer who is not currently receiving CST, the treating provider will submit a complete Request for Authorization of CST that includes:

1. LOCUS information for adults and Ohio Scales information for youth;
2. A treatment plan;
3. The consumer's initial crisis plan or youth/family crisis plan.

Once the initial CST request is submitted, the documents will be reviewed for adherence to clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services the Collaborative will enter an authorization for 90 days of services.

If the consumer continues to need CST services, the CST team must submit a reauthorization request before the initial authorization expires. This request should be submitted within two weeks prior to the initial authorization expiration date.

REAUTHORIZATION PROCESS for CST

To request a reauthorization for a consumer who is currently receiving CST, the treating provider will submit a complete request for authorization of CST packet that includes:

1. The Request for Authorization of CST form that includes LOCUS information for adults and Ohio Scales information for youth;
2. An updated CST treatment plan;
3. The consumer's crisis plan or youth/family crisis plan.

A LOCUS assessment should to be completed for adults as part of the authorization request. Typically a composite score of 4 indicates that the individual's needs are so pervasive and/or unpredictable, it is unlikely that other combinations of available community services have been or would be effective. There is a section on the request form where the provider can explain the variance between the clinical presentation and a LOCUS score below 4. Typically the LOCUS score is updated at the time of a treatment plan review or when the consumer's clinical condition warrants.

An Ohio Scales assessment should be completed for all youth as part of the authorization request. The scale will indicate if there are changes in the severity of symptoms or functioning of the youth. A score of 37 or higher on the problem scale will indicate the need of CST intensity of service.

Once the request for reauthorization of CST services is submitted, the documents will be reviewed for adherence to the clinical criteria based on the service definitions, Rule 132, and the authorization treatment guidelines. If the clinical criteria are met for services, the Collaborative will enter an authorization for up to 180 days of services.

If the clinical criteria are not met, the Collaborative will either authorize a 30 day transition period or the Collaborative will deny the requested service.

If the consumer continues to need CST services, the CST team is to submit a reauthorization request before the current authorization expires. This request should be submitted within two weeks prior to the current authorization expiration date.

Transition to or from CST services
When a consumer is transitioning into or out of CST, Community Support Individual (CSI), Community Support Residential (CSR), or ACT can be provided (in addition to CST) when clinically indicated for a period of 30 days.

In order to facilitate reimbursement, the CST provider must submit an updated Request for Authorization for CST completing the Transition Plan section and indicating the additional services that are clinically indicated. These additional services should also be included on the Individualized Treatment Plan. Examples of when this may occur include:

1. Crisis Residential: When an individual requires crisis residential to avert a hospitalization, CST services should continue in addition to the residential services. The provider should indicate the need for Community Support Residential that the client requires during the crisis residential stay.
2. Assertive Community Support Team: When an individual is being transitioned to Assertive Community Treatment, ACT should be indicated in the Transition Plan of the Request for Authorization for CST form. In addition, a Request for Authorization for ACT form must be submitted by the ACT provider.

Discontinuation of CST services:

Providers must notify the Collaborative when a consumer is discontinuing CST services by completing a "Notification of Discontinuance of CST Services" form and faxing it to the Collaborative or by entering the information in ProviderConnect. Discontinuance of CST services shall occur when:

1. Person requests termination from CST and is currently stable.
2. Person has improved to the extent that CST is no longer needed and recovery goals have been met.
3. Person has moved out of the CST Teams' geographic area (provide linkage information to the new CST Team or community service).
4. Person has moved out of State (make attempts to link with other CST or community services).
5. Person cannot be located, in spite of repeated CST efforts. (Describe efforts to locate and

continue CST services such as number of failed contacts, time elapsed since last contact, lack of leads on whereabouts from the person's emergency contact list)
6. Person is deceased.

Detailed information regarding discontinuance of CST services and linkage to other services must be documented in the consumer's clinical record.

Reasons for Medical Necessity denials of CST services
There is not evidence that the individual has exhibited 3 or more of the following (Rule: 59 Ill. Adm. Codes 132.150):
1. Multiple and frequent psychiatric inpatient readmissions, including long term hospitalization;
2. Excessive use of crisis/emergency services with failed linkages;
3. Chronic homelessness;
4. Repeat arrest and incarceration;
5. History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing;
6. High use of detoxification services (e.g., two or more episodes per year);
7. Medication resistant due to intolerable side effects or their illness interferes with consistent self-management of medications;
8. Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated clinical and supportive interventions;
9. Because of behavioral health issues, the child or adolescent has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent;
10. Clinical evidence of suicidal ideation or gesture in last three (3) months;
11. Ongoing inappropriate public behavior within the last three months including such examples as public intoxication, indecency, disturbing the peace, delinquent behavior;
12. Self harm or threats of harm to others within the last three (3) months;
13. Evidence of significant complications such as cognitive impairment, behavioral problem or medical problems.

C**linical Denial Reasons for requests to continue CST Services**
There is no evidence that one or more of the following continue to exist:

- The person's severity of illness and resulting impairment continues to require CST;
- Services are consistent with the person's recovery goals and are focused on reintegration of the individual into the community and improving his/her functioning in order to reduce unnecessary utilization of more intensive treatment alternatives (e.g., residential or inpatient);
- The mode, intensity, and frequency of treatment is appropriate;
- Active treatment is occurring and continued progress toward goals is anticipated;
- The services listed above are provided as needed and agreed upon in the treatment plan by providers and the individual, and for youth, the family;
- The individual continues to require services in order to maximize functioning and sustain recovery or individual's support network (e.g., family, friends, and peers) is insufficient to allow for independent, or age appropriate living;

- Individual has persistent/severe psychiatric symptoms, serious behavioral difficulties, a co-occurring disorder, and/or medical or alcohol/substance abuse disorder.

Request for Authorization of Community Support Team Services (CST)

☐ Initial Request or ☐ Reauthorization Request (youth or adult)

Fax Request Form to the Collaborative at: 866-928-7177

Agency: _____ Agency Location:_____ Agency FEIN:_____ **Team Name:** _____	**Name of Referred**: _____ **Date of Birth**: _____ **RIN #** _____
Male: ☐ **Female:** ☐	**Date CST Services Started:**_____
Current Medications; (name, dose, frequency)	

I. SERVICE DEFINITION CRITERIA (Please check all that apply)

☐ Multiple and frequent psychiatric inpatient admissions
☐ Excessive use of crisis or emergency services with failed linkages
☐ Chronic homelessness
☐ Repeat arrests and incarcerations
☐ History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow through taking medications, following a crisis plan, or achieving stable housing
☐ High use of detoxification services (e.g., two (2) or more episodes per year)
☐ Clinical evidence of suicidal ideation or behavior in last three (3) months
☐ Ongoing inappropriate public behavior within the last three months such as public intoxication, indecency, disturbing the peace, delinquent behavior
☐ Self harm or threats of harm to others within the last three (3) months
☐ Medication resistance due to: intolerable side effects or illness-mediated interference with consistent self-management of medications
☐ Evidence of significant complications such as cognitive impairment, behavioral problem or medical problems
☐ *For Youth Only:* Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated clinical and supportive interventions
☐ *For Youth Only:* Because of behavioral health issues, the child or adolescent has shown risk of out-of-home placement or is currently in out-of-home placement and reunification is imminent

II. DIAGNOSIS

DSM Diagnosis ***All 5 Axes must be completed***	**Diagnosis (Code)**	**Rank** **(Please rank diagnoses in Axes 1-3 in order of primacy)**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF) or C-GAF	Highest Last Year:	Current:

Agency: _____ **Name of Referred**: _____

Date of Birth: _____ **RIN #** _____

III. FUNCTIONAL IMPAIRMENT (**Fill out all domains from the LOCUS tool)**

Domain Scores: Risk of Harm: _____ **Recovery Environment - Environmental Stressors:** _____

Recovery Environment – Environmental Support: _____ **Functional Status:** _____

Co-morbidity: _____ **Recovery and Treatment History:** _____ **Acceptance and Engagement:** _____

LOCUS RECOMMENDED LEVEL OF CARE: **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

ASSESSOR RECOMMENDED LEVEL OF CARE (according with services crosswalk)

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

Reason for deviation (if applicable)
Explain:

IV. OHIO SCALE RESULTS

Worker Ohio problem severity scale (0-100) _____

V. TRANSITION PLAN (NARRATIVE)

This section is to be used when CST authorization is requested as part of a transition plan. (Please write legibly.)
Please describe the clinical need for the transition to less intensive services or more intensive services (such as ACT)

List additional services that are clinically indicated:

TRANSITION START DATE: TRANSITION END DATE:

The medical necessity for this Request for Authorization and the attached Treatment Plan is recommended by an LPHA and is based upon a completed Comprehensive Mental Health Assessment that is in the consumer's clinical record and available upon request.

☐ Yes

Please note that incomplete forms will be returned

Notification of Discontinuance of Community Support Team

Fax Form to the Collaborative at: 866-928-7177

Agency: _____	**Name of Referred**: _____
Agency Location:_____	**Date of Birth**: _____
Agency FEIN:_____	**RIN #** _____
Team Name: _____	

Male: ☐ **Female:** ☐

Admit Date to CST:_____

CST was discontinued on (date) _____

I. DISCONTINUATION CRITERIA (please check one)

☐ Person requests termination form CST and is stable
☐ Person has improved to the extent that CST is no longer needed and recovery goals have been met. (No medical necessity for CST – please attach transition plan)
☐ Person has moved out of the CST Teams' geographic area (provide linkage information to new CST Team or community service)
☐ Person has moved out of State (make attempts to link with other CST or community services)
☐ Person cannot be located, in spite of repeated efforts. (Describe efforts to locate and continue CST services such as number of failed contacts, time elapsed since last contact: lack of leads on whereabouts from the person's emergency contact list.)
☐ Person requests termination from CST despite the clinical recommendation of the team
☐ Person has been incarcerated
☐ Person is in need of hospitalization that may exceed 90 days
☐ Person is in need of nursing facility level of care that may exceed 90 days
☐ Deceased

II. DIAGNOSIS

DSM Diagnosis *All 5 Axes must be completed*	**Diagnosis (Code)**	**Rank (Please rank diagnoses in Axes 1-3 in order of primacy)**
Axis I		
Axis II		
Axis III		
Axis IV		
Axis V - Global Assessment of Functioning (GAF) or C-GAS	Highest Last Year:	Current:

Agency: _____ **Name of Referred**: _____

Date of Birth: _____ **RIN #** _____

III. LOCUS SCORE FOR ADULTS AT TIME OF DISCONTINUATION

Domain Scores: Risk of Harm: _____ **Recovery Environment - Environmental Stressors:** _____

Recovery Environment – Environmental Support: _____ **Functional Status:** _____

Co-morbidity: _____ **Recovery and Treatment History:** _____ **Acceptance and Engagement:** _____

LOCUS recommended level of care at time service is being discontinued **Composite Score:** _____

☐ Level I ☐ Level II ☐ Level III ☐ Level IV ☐ Level V ☐ Level VI

IV. OHIO SCALE FOR YOUTH AT TIME OF DISCONTINUATION:

Worker Ohio problem severity scale (0-100) _____

V. TRANSITION PLAN – If applicable (NARRATIVE) (Please write legibly.)

Clinical staff to contact with any questions (print) _____

Phone: (_____)_____ Fax Number: (_____)_____

Encrypted email address: _____

CRISIS AND TEATMENT PLANS

ADDITIONAL FORMS TO REQUEST AUTHORIZATION

In addition to the Request for Authorization Form, the provider shall submit the current treatment plan and crisis plan for the consumer.

TREATMENT PLAN

The consumer's treatment plan (ITP) is required to be submitted as a part of the authorization process to assure clinical congruence between the goals / interventions listed in the individual treatment plan and the service definition criteria and the LOCUS score. For example if a consumer scores a "4" on the risk of harm scale as a result of a recent increase in substance abuse that result in harmful behaviors, the Collaborative will look for that issue to be addressed in the ITP. The treatment plan submitted to the Collaborative as a part of the treatment request should comply with Rule 132, and be driven by the documented assessment.

ELEMENTS OF A CRISIS PLAN

As recovery and choice are hallmarks of the Illinois Mental Health Collaborative for Access and Choice, a consumer-driven crisis plan will be required as a part of the authorization process for ACT and CST. In the case of youth, a youth/family crisis plan is required. This is a step the Collaborative is taking to assure that the consumer has had an opportunity to express his or her wishes for how s/he wants to be cared for in case of a crisis. The crisis plan is a dynamic process and not a static experience. These plans are voluntary at their core, but should be used as a point for engagement into care. Thus, a consumer's initial crisis plan may only have one item such as, "this is how I know when I need help" or "this is who to call when I need help". Even if the individual is in a crisis at the time of intake, the crisis plan can be used as a part of the crisis resolution process, to assure next steps are appropriate for the consumer's progress towards his or her goals. The crisis plan can be an effective tool in engagement, and sets the stage for consumer choice and recovery focus. When consumer engagement is an issue, the crisis plan can be used as an effective tool for dialogue between the clinician and the consumer. Crisis plans are typically updated during the annual review process or when the consumer chooses to change a previous plan based on current life circumstances.

There are three types of consumer plans to prepare for or prevent a crisis. They include:
1. Crisis plans
2. Wellness Recovery Action Plan (WRAP)
3. Advanced directives

Crisis Plans

Providers are free to develop a consumer crisis plan document that is easily integrated into their system or a part of their electronic medical record (EMR). The basic elements of the Crisis plan can include:

1. What I am like when I am not feeling well:
2. Signs that I need help from others:
3. Who to call when I need help (My support team):
4. Who to not call when I need help:
5. My medications are:
6. I take medication to:
7. My doctor or provider is:
8. This is what usually works when I need help:
9. Please make sure someone on my support team takes care of:

For a youth/family crisis plan, basic elements can include:

1. We need help with daily monitoring when:
2. We need help to show our youth how to ask for help when:
3. Who can we call at night or on the weekends when we are stressed:
4. How do we help our child manage the side effects of their medication:
5. How do other parents cope:

Wellness Recovery Action Plans (WRAP)

WRAP is a self management and recovery system developed by a group of people who had mental health difficulties and who were struggling to incorporate wellness tools and strategies into their lives.

WRAP is a structured system to monitor uncomfortable and distressing symptoms that can help reduce, modify or eliminate symptoms by using planned responses. The goal of WRAP is to teach people recovery, self management skills and strategies to deal with mental illness.

By definition the recovery process must be self directed. The individual designs and directs their own WRAP plan. This is more than a one time occurrence. The WRAP plan is ever changing and always is based on personal choice.

(as defined by the Copeland Center **www.mentalhealthrecovery.com)**

Advanced Directives

The Advance Directive serves a similar purpose to a Crisis Plan, but is a *legal document* created when a person is well. It describes what kind of mental health treatment the consumer would allow and what person can make decisions about the consumer's care if they consumer becomes unable to due to illness. *Only the consumer can decide to create an Advance Directive and what it contains.* There are two types of advanced directives one is specific for mental heath care and the other is a general directive for all health care needs including mental health.

A Declaration for Mental Health Treatment includes consumer preferences about:

- Medication
- Hospitalization
- Electroconvulsive Therapy (ECT)
- "Attorney in Fact," who can view the consumer's mental health records and make decisions about care, on behalf of the consumer.

A Power of Attorney for Health Care:

- Can direct both mental health treatment and other medical care.

Advance Directives are legal documents, therefore the consumer should get advice from people who know a lot about them. It is important to be well informed about the process and involve people the consumer can trust. Psychiatric Advance Directives are voluntary. Free advice and assistance is available:

Equip for Equality: Main Office
20 North Michigan Avenue, Suite 300
Chicago, IL 60602
(800) 537-2632 (Voice)
(800) 610-2779 (TTY)
www.equipforequality.org

Illinois Guardianship and Advocacy Commission: Legal Advocacy Service
1-866-274-8023
http://www.gac.state.il.us/mhtp.html

RESIDENTIAL SERVICES

To be developed.

INDIVIDUAL CARE GRANT

Eligibility

The Individual Care Grant is for children and youth with severely impaired reality testing, having symptoms which do not indicate an acute episode, having had an appropriate trial of inpatient, outpatient and/or community based treatment. Applicants must be enrolled in an approved educational program, must be less than 17 years of age and six months (17 ½ yrs) at the time of application, not under the guardianship of a State agency, and their parent/guardian must be an Illinois resident.

There are no changes in the eligibility requirements for Rule 135 services. A determination of eligibility is made by a Collaborative Illinois licensed clinical social worker after a formal review of the child's mental health records and treatment history.

Application

Parents contact the Collaborative to request an application. At the time of the call, information is taken as part of the intake process. There is no change in the application requirements. An application is then mailed to the parent/guardian with instructions to ensure that all necessary information is collected for submission of a complete application.

The SASS agency is notified at the same time that an application packet is sent to the parents. SASS workers are available to assist the family in completing the application.

Completed applications are returned to the Collaborative for review. Reviews of all complete applications are completed within 30 days of receipt. Incomplete applications are returned to the parent/guardian within 15 days of receipt. A cover letter will identify the missing information.

Services

The Collaborative assumes responsibility for reviewing all applications on April 1, 2008. Once eligibility is determined, the parent/guardian is encouraged to meet with the SASS worker and complete a service plan for the child/adolescent. Treatment options include residential placement, specialized community services or a deferment (deferments are only for 12 months; after that time, the parent/guardian must re-apply). Parents will continue to choose the type of service for their child/adolescent.

Community based services will continue to be handled by the DHS/DMH Child and Adolescent Division. Residential services will be managed by the Collaborative. The Collaborative will be responsible for reviewing quarterly reports and conducting the annual review. SASS site visits are still required. The Collaborative will participate in monitoring site visits.

ICG Appeals Process- Secretary Level of Appeal

The Collaborative receives parents appeal and forwards them to the State for a Secretary Level Appeal. Parents may appeal a denial of ICG eligibility within 40 days of receipt of the denial notice. The written appeal must provide in detail each basis on which the appeal is being made, specifically stating each reason that the denial of the eligibility is alleged to be improper. Parents will be notified directly by DHS/DMH of the outcome of the appeal. The Collaborative will track and report on the appeals process which includes time frames for processing and the notification of the outcome of the Secretary Level Appeal. Parents can submit a new application during the appeal process.

REFERENCE DOCUMENTS

Crisis Plan Samples

SAMPLE #1

Individual Crisis Plan

Name: _____

Address: _____

Phone Number: _____

My Informal Support Team includes

1. _____

2. _____

3. _____

My Formal Support Team includes

Family Doctor: _____

Psychiatrist: _____

What I Would Like To Happen if I Am In Crisis As A Result Of Mental Illness

Suggestions: Use separate sheets for various types of Crisis Situations and your Plans to resolve them. Focus on specific situations and the resolution for each including the Support Members who can best help you in each particular situation.

Crisis A)

The Situation:
My Plan:

or

Crisis B)

The Situation:
My Plan:

Support Person's Name _____ Phone Number: _____

Consumer Signature: _____ **Date**: _____

Witness Signature**:** _____ Date**:** _____

SAMPLE #2
Consumer Crisis Plan

Client Name: _____ **Date:** _____

SYMPTOM FLARE-UP MANAGEMENT SHEET

A. The circumstances that tend to cause me stress and may lead to a symptom flare-up include:

_____

_____

_____

(Examples: *holidays, losing a job, failing a class, substance use*)

B. The first signs that I notice that indicate that I am under stress and at risk for a symptom flare-up are:
1. _____
2. _____
3. _____
4. _____

(Examples: *feeling tense, not being able to sleep, feeling suspicious of others*)

C. The first signs that OTHERS notice that indicate that I am under stress and at risk for a symptom flare-up are:
1. _____
2. _____
3. _____
4. _____

(Examples: *wearing particular clothing, a specific facial expression, being up all night*)

D. When I am under stress and I, or others, notice that my symptoms may be flaring up, my family or friends and I agree to do the following to reduce the likelihood of a things getting worse:
1. _____
2. _____
3. _____
4. _____

(Examples: *trying to reduce stress by going for a walk, calling a friend to talk, calling my case manager about a medication adjustment, family will try to "give me my space"*)

SUBSTANCE ABUSE RELAPSE PREVENTION WORKSHEET

A. The early warning signs that I may be about to experience a relapse of my substance use are:
   1. _____
   2. _____
   3. _____
   4. _____

   (Examples: *going to places where I used to use, hanging out with people I used to use with*)

B. Feelings I experience when I want to start using substances again are:

1. _____
2. _____
3. _____
4. _____

(Examples: *anger, hurt, sadness, boredom*)

C. Plan to be implemented when early warning signs or feelings appear:

1. _____
2. _____
3. _____
4. _____

(Examples: *call a support person, call my case manager, go to a 12 Step meeting, call my doctor*)

Doctor's Name: _____ Phone Number: _____

Therapist/Case Manager's Name: _____

_____ Phone Number: _____

Support Person's Name _____ Phone Number: _____

Support Person's Name _____ Phone Number: _____

Support Person's Name _____ Phone Number: _____

Consumer Signature: _____ **Date**: _____

Witness Signature: _____ **Date**: _____

Certified Recovery Support Specialist (CRSS) Credential:

The CRSS is a credential for people who provide mental health peer support services to others. Certified Recovery Support Specialists use unique insights gained through personal recovery experience. The CRSS assures competency in:

- Advocacy
- Professional Responsibility
- Mentoring
- Recovery Support

Family Resource Developer:

A Family Resource Developer must be a parent or care-giver who has navigated multiple child serving systems on behalf of a child or adolescent with Severe Emotional Disturbance (SED) as a consumer of the mental health system.

Homeless Definition

"Homeless Person" as defined by the U.S. Department of Housing and Urban Development (HUD) as: An individual who lacks a fixed, regular, and adequate nighttime residence; An individual who has a primary nighttime residence that is:

- A shelter designed to provide temporary living accommodations (including welfare hotels, congregate shelters, and transitional housing for the mentally ill)
- An institution that provides a temporary residence for individuals intended to be institutionalized
- A public or private place not designed for, or ordinarily used as, regular sleeping accommodations for human being

LOCUS Scale and other resources can be found at:

http://www.dhs.state.il.us/page.aspx?item=32545

Ohio Scale- resource:
Ogles, B. 2000, Ohio Mental Health Consumer Outcomes System: Ohio Youth Problem, Functioning and Satisfaction Scales, Agency Worker Rating – Short Form. Southern Consortium for Children.