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DHSS Behavioral Health FY 2014 - 2016
Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

DHSS Behavioral Health FY 2014 - 2016
Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

Psychiatric Emergency Services (PES) - Program Type #1

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.030 – 70.990
- 7 AAC 135.010 – 40 Medicaid Coverage: Behavioral Health Services

Target population: The Comprehensive Behavioral Health Center (CBHC or "grantee") funded to provide **psychiatric emergency services (PES)** shall serve all people in the grantee's service area who are in need of emergency behavioral health services, regardless of ability to pay.

PART A. CORE SERVICES AND REQUIREMENTS Grantees providing psychiatric emergency services have the following **core** responsibilities:

1. **Access.**
   Standard: CBHC's shall inform service area residents of the availability and manner in which local / regional emergency services can be accessed.

   Criteria 1a: Publicize Availability of PES. The grantee shall take measures to inform the residents / agencies in the grantee's service area how the public can access psychiatric emergency services (e.g., employing public service announcements, phone directory listings, public presentations, brochures).

   Criteria 1b. Services Available to All Service Area Residents. Psychiatric emergency services are rendered to any resident of the grantee's service area, regardless of ability to pay and whether the resident is presently an enrolled CBHC client or a beneficiary, or a non-beneficiary or a person unknown to the CBHC and its clinicians.

2. **Availability.**
   Standard: CBHC's with PES grants have a 24/7 responsibility for all residents experiencing a behavioral health emergency in the grantee's service area, including present clients of the grantee.

   Criteria 2a: Availability of Masters-trained PES Staff. The grantee shall ensure that a master's level clinician, as defined in 7 AAC 70.990(28), is available 24/7 to respond to emergencies.

   Criteria 2b: Availability of a Range of PES Services. The psychiatric emergency services provided by the CBHC include crisis intervention and clinical screening, and assessment.

   Criteria 2c: Availability of 24/7 Crisis Line Services. Within the grantee's service area, initial behavioral health emergency phone calls are the responsibility of the grantee; however, these required crisis line services may be covered or provided by an affiliated service (i.e., the grantee's after-hours answering service; a community- or service area-wide crisis hotline; a phone in a local emergency room), so long as that

service has the ability to immediately contact the grantees' on-call clinician when informed of a behavioral health emergency. AS 47.30.056 (I (2) (A)

3. **Response.**
Standard: While some interventions will inevitably lead to hospitalization, grantees are encouraged to pursue options for stabilizing clients locally; thus, where possible, referrals to local programs and services are preferred. *[In many instances, there is less disruption to a person's / client's life if he or she can be supervised in a safe place close to home while medications (if prescribed or available) are adjusted by a local provider.]*

Criteria 3a: Local Response Services. Screening, assessment, and intervention services are provided by the grantee's Behavioral Health clinicians when a person in crisis presents with suicidal or homicidal ideation, or is gravely disabled and likely to need hospitalization.

Criteria 3b. Emergency Appointment / Contact Response Time. A Behavioral Health clinician informed of an emergent matter must respond (face-to-face or by phone) to the request for emergency intervention / evaluation services within two (2) hours of contact by the crisis line responder.

Criteria 3c: Knowledge of Commitment Procedures. Whenever necessary, a grantee's clinician petitions for involuntary commitment orders and arranges for secure transportation of the persons in crisis to evaluation or treatment services at a Designated Evaluation and Stabilization (DES) or a Designated Evaluation and Treatment (DET) Hospitals, or Alaska Psychiatric Hospital (API).

Criteria 3d. CBHC Follow-Up Services for Persons Not-Hospitalized. Local behavioral health crisis follow-up services shall be provided by appropriate CBHC staff (not limited to PES staff) to ensure that the behavioral or psychological concerns associated with the individual's acute distress, impairment, or risk phase, have been sufficiently resolved that the individual no longer presents as a danger to themselves or others or is gravely disabled. This follow-up is intended to ensure stabilization and safety.

4. **Post-Hospitalization Follow-Up.**
Standard: Good continuity of care requires that persons discharged from psychiatric hospitalizations should be connected – or re-connected – to after-care services through their local CBHC as quickly as possible.

Please note: DBH will require API and DES and DET hospitals to schedule a post-hospitalization after-care referral with a CBHC (or private practioneers) within a week of the patient's planned discharge date. Prior to a patient's discharge, an API social worker – or a social worker at the DES or DET hospital where a patient is hospitalized – will schedule a follow-up appointment for the patient with the CBHC nearest to the patient's residence or discharge placement. The appointment will occur no later than five (5) calendar days of the patient's planned date of discharge.

Criteria 4a. CBHC's Role in Scheduling a Follow-up Appointment. A CBHC shall accommodate all requests for post-hospitalization follow-up appointments from API, North Star, other hospitals, including DES or DET hospital social workers. The CBHC

will ensure that such appointments are scheduled at its clinic within five (5) calendar days of the patient's date of discharge, and will, if possible, provide the hospital social worker with the name of the clinician with whom the discharged patient's intake or counseling session is scheduled.

Criteria 4b. Documentation of the Follow-up Appointment. It is the intent of this Criteria that every hospitalized psychiatric patient will see a CBHC clinician within no more than (5) calendar days of their date of discharge from the hospital. To this end, the CBHC will make every attempt to telephonically reconfirm any CBHC appointment made for a person while they were hospitalized and encourage that person's on-time appearance for their scheduled CBHC intake (if a new client) or follow-up counseling session (if a current client).

A special *after-care log* of all scheduled post-hospitalization follow-up appointments will be maintained by the CBHC, creating a record by patient/client name that includes i) the date of initial appointment (see Criteria 4a above); ii) any follow-up calls made to the recently discharged patient (before the first post-discharge appointment and any calls to follow-up on a "no show"); iii) any rescheduled appointment(s); and iv) the date of an appointment kept or missed by the recently discharged patient. The log should be maintained in a standardized format established by the division.

5. <u>Face-to-Face Contact Required.</u>
Standard: Whenever possible, psychiatric emergency evaluations by Behavioral Health clinicians occur face-to-face.

Criteria 5a. Face-to-Face Contact Required. Except as noted in Criteria 5b, every emergency contact with an individual experiencing a psychiatric crisis (whether expressing suicidal or homicidal ideation, or gravely disabled and likely in need of hospitalization) requires a face-to-face intervention, including screening and assessment services; however, a telebehavioral health consult may be employed when available and as appropriate.

Criteria 5b. Service Location. These crisis intervention services are provided in any location that provides reasonable safety for the individual in crisis and the grantee's (on-call) clinician (e.g., a CBHC clinic office, a school, the local jail, a hospital emergency room). If the Behavioral Health clinician is *more than 50 miles away* from the resident in crisis, or if unusual weather or road conditions preclude the clinician's travel, then telephonic consultative services are provided by the clinician individually or in collaboration with an emergency responder closer to the resident in crisis.

PART B. CONTINUITY OF CARE.

Standard: Psychiatric emergency services must be closely linked with local, ongoing behavioral health treatment and rehabilitation services, in order to ensure continuity of care for the recipient of CBHC services.

Grantees providing psychiatric emergency services have the following responsibilities with respect to meeting appropriate continuity of care expectations:

Criteria 6. The Grantee has a Written Disaster Response Plan. Grantees are required to have a Disaster / Emergency Response Plan in place that not only describes how the agency

and its staff will respond to a disaster or emergency that impacts the ability of the agency to operate normally and maintain its commitment to the safety of its staff and its clients, but also how the grantee's behavioral health resources will be employed / deployed in a local or service-area-wide natural or man-made disaster. The plan should address CBHC staff call-back procedures following a disaster, once staff have confirmed the status of their own family members, as well as the role CBHC clinical staff will assume in providing counseling services to area residents in need of support following a disaster.

Criteria 7. The Grantee has a MOA with the Nearest Local or Regional Hospital. The grantee will develop a written memorandum of agreement with any hospital within 50 miles of the grantee's main office, including DES and DET facilities. The MOA will describe grantee and hospital responsibilities when responding to a local or service area behavioral health crises, including the option for shared emergency on-call services (so long as there is 24/7 community service area coverage). Where appropriate and applicable, the agreement will also describe the process for a hospital's credentialing of grantee's mental health professionals and masters-level clinicians, so that Behavioral Health clinical staff are able to provide face-to-face patient screenings and assessments in the hospital's emergency department or acute care treatment unit (especially for other than DET hospitals).

Criteria 8. The Grantee Maintains MOAs with Local Law Enforcement. The grantee will develop written agreements with local and service area law enforcement agencies for the handling of psychiatric emergencies, including protocols for grantee mental health professionals and master's level clinicians to provide face-to-face screening and assessment at jails, juvenile detention facilities (if located within 50 miles of the grantee's clinic), and local hospitals. Screening and assessment shall include petitioning for commitment orders, if necessary and regular re-assessments of persons in crisis being held for transport.

Criteria 9. The Grantee May Rely on Associated Community / Village Persons to Assist When the Crisis is More than 50 Miles from a CBHC Office. If the grantee office is located more than 50 miles from the client in crisis, or is not on the state road system, the on-call Behavioral Health clinician may assist local health / behavioral health aides or other reliable persons to assist Village Public Safety Officers **(**VPSOs**)** or Village Safety Officers (VSOs) to screen and assess clients for emergency detention. The VPSO / VSO may file the MC-105 form, titled "Notice of Emergency Detention and Application for Evaluation" (formerly known as a Peace Officer Application or POA). The on-call clinician must be available by phone or radio for support to this process, which will allow the person experiencing a behavioral health crisis in a rural community to be transported to the nearest local or regional hospital for assessment and potential involuntary commitment for evaluation or treatment.

Detoxification Services - Program Type #2

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.010 – 70.990 (especially note: 7 AAC 70.110)
- 7 AAC 135.010 – 40 Medicaid Coverage: Behavioral Health Services (especially note: 7 AAC 135.190)

Target Population: The detoxification services provided by a Community Behavioral Health Center under a Comprehensive Behavioral Health Treatment and Recovery (CBHTR) Grant are intended to serve adult patients who, because of their use of alcohol and / or other drugs including opioids are frequent users of detoxification services, emergency medical services, public safety services, the emergency rooms of acute care hospitals, or API.

Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users, and women with children.

PART A. CORE DETOXIFICATION SERVICES AND REQUIREMENTS Grantees funded to provide detoxification services have the following **core** responsibilities as defined in 7 AAC 70.110.

1. **Admission Services.**
   Standard: Admission to Detoxification Services will be based on the criteria delineated in the Substance-Related Disorder category as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR) and the current SUD Patient Placement Criteria defined by the American Society of Addiction Medicine (ASAM PPC-2R).

2. **Co-occurring Services.**
   Standard: If, as a client progresses through detoxification, the client is determined to have a co-occurring psychiatric diagnosis that actively impacts – or may actively impact – the rate of a client's successful progress through treatment, it is incumbent on the grantee to seek qualified mental health assessment and clinical services for the patient as a part of the developed plan of care.

3. **Discharge Planning**.
   Standard: Comprehensive discharge planning will begin at admission, and based on the results of the client's substance use disorder assessment, will address such matters as referrals for SUD treatment (inpatient or outpatient), mental health treatment, housing, case management, initiation of family counseling, etc.

4. **General Statutory and Regulation Compliance**
   DBH grantees funded to provide detoxification services must meet all current regulatory requirements found in the Alaska Administrative Code, including 7 AAC 70.100 – 7 AAC 70.160; 7 AAC 70.200 – 7 AAC 70.260; and 7 AAC 70.010 – 7 AAC 70.060; and the statutory requirements set forth in AS 47.37.140.

PART B. AMBULATORY AND NON-AMBULATORY RESIDENTIAL DETOXIFICATION SERVICES DBH grantees funded to provide detoxification services may offer the following levels of care:

1. Non-Ambulatory Residential Detoxification Services.
Standard: Non-ambulatory detoxification patient services are provided by a grantee in a permanent facility with 24-hour observation and supervision by properly trained staff that provides structure and support to patients during the course of the client's treatment for detoxification. Non-ambulatory (i.e., inpatient) detoxification services are divided into two types: clinically managed or medically monitored.

1a. Clinically Managed Detoxification Services. (Defined in 7 AAC 70.110 (c, 1-6) (f-i)

(i). Staff providing clinically managed detoxification services may supervise a patient's use of self-administered medications for the control of the client's withdrawal symptoms;

(ii). Staff providing clinically managed detoxification services must have the ability to determine the appropriateness and necessity of transferring clients in need of medical services to a hospital.

1b. Medically Monitored Detoxification Services. (Defined in 7 AAC 70.110 (d, 1-8) (f-i)

(i). A grantee offering medically monitored detoxification services provides observation and supervised evaluation and withdrawal management delivered by qualified medical and nursing professionals in a hospital or permanent inpatient facility, with 24-hour observation, monitoring, and treatment.

(ii). Note: medically monitored detoxification is not necessary for individuals who are actively using **only** cocaine, marijuana, or amphetamines. These individuals are not appropriate for Medically Monitored Residential Detoxification.

2. Ambulatory Detoxification. (Defined in 7 AAC 70.110 (b. 1-6) (e-i))
Standard: A Behavioral Health Center grantee offering ambulatory (i.e., outpatient, non-residential) detoxification services provides treatment to individuals who are actively abusing and dependent on alcohol, other drugs, or opioids, and is able to minimize the residential stays for these because these clients have adequate social or family support systems in place and their medical condition(s) does not require a higher level of (non-ambulatory) detoxification services.

A client of an ambulatory detoxification grantee must be concurrently receiving outpatient or residential substance abuse (not detoxification) treatment services.

Detoxification is generally not necessary for individuals who are actively using only cocaine, marijuana, and amphetamines and therefore they are not appropriate for Ambulatory Detoxification.

2a. Ambulatory Detoxification Services *without* Extended Onsite Monitoring This level of care is currently not defined in regulation. All program approvals require an agency to meet the standard for ambulatory detox with extended on-site monitoring.

(i). Ambulatory detoxification *without* extended onsite monitoring is an organized outpatient service which the grantee may provide in an outpatient office, clinic or treatment facility.

(ii). Grantees offering this lower level of onsite monitoring shall utilize trained clinicians who provide medically supervised evaluation, detoxification, and referral services according to a publicized, predetermined program. These planned services are provided in regularly scheduled sessions and are delivered under a defined set of grantee published policies and procedures and in accordance with identified, available medical protocols.

2b. Ambulatory Detoxification Services *with* Extended Onsite Monitoring

(i). Ambulatory detoxification *with* extended onsite monitoring is similar to ambulatory detoxification without extended onsite monitoring (see 2a above), with the following *exceptions*:

- The grantee's onsite monitoring services are not necessarily accessed at established hours or set according to a predetermined schedule, but the sessions held must be sufficient in number and time to effectively monitor and educate an individual regarding the stages of the detoxification process the individual is going through and assist the trained grantee staff in determining the individualized effects of each client's own withdrawal process;

- An ambulatory detoxification services program *with* extended onsite monitoring is appropriate for those clients who may be dually diagnosed, i.e., clients who have co-occurring mental health and substance abuse issues, with a primary focus on the need for SUD treatment, but whose psychiatric issues are such that active mental health treatment must be a key part of the patient's outpatient treatment plan and be managed accordingly.

PART C. MISCELLANEOUS

1. **Current Activity Schedule.** Grantees providing detoxification services have a current activity schedule that provides an amount of active treatment that is consistent with the program's stated ASAM level of Care and the standards as outlined in 7 AAC 70.110.

2. **Readmission for Detoxification.** The number of detoxification attempts for individuals may vary according to the degree and severity of addiction, drugs to which addicted, health and well-being, and support services necessary to assist an individual in their recovery. Participants who fail to complete a stay in detoxification shall not be held to a set number of days before consideration for readmission. If they present again for admission, they shall be readmitted based upon available space and clinical need. ***Each case shall be evaluated on an individual basis.***

3. **Disaster/Emergency Response Plan.** Grantees are required to have a Disaster/Emergency Response Plan in place that describes how a grantee's behavioral health resources will be employed/deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, clients and family members following a disaster, as well as the role staff will assume in providing counseling services to clients.

Youth Residential Substance Use Disorder Treatment Services - Program Type #3

Target Population: The program is intended to serve youth who have not attained the age of eighteen years and who are abusing or dependent upon alcohol or other drugs, including inhalants, prescribed, and over-the-counter medications. **Priority admissions are required for pregnant injection drug users, pregnant adolescents, injection drug users, adolescents with children and referrals from the Office of Children's Services, Division of Juvenile Justice and youth in foster care.**

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 -70.990 **Note: 7 AAC 70.120**
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services (especially note: 7 AAC 135.280.)

DHSS/BH will only fund the following Youth Residential service type:

Level III.5 Clinically Managed High-Intensity Residential Services 7 AAC 70.120 (a-e; h) (*20 or more hours of clinical/rehabilitation services per week)* Agencies must be approved to provide clinically managed high intensity residential services under 70.120 and clinic services under 70.030 to support the requirement for clinic services listed below.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS Behavioral Health encourages grantees to employ evidence-based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS Behavioral Health recognizes that some effective treatment programs employ a variety of therapies and services that meet the needs of individual clients.

Core services and requirements:

- Medical clearance and referral for medical treatment as needed;
- Program orientation and intake/admission;
- Linkage to community based support groups.
- Agencies are encouraged, but not required, to explore the use of Peer Support Services delivered by parents of youth who have experience in supporting the recovery to their children is encouraged. However, research indicates that young adults in recovery do not have sufficient maturity, time in recovery or life experiences to be effective. Consequently, agencies are urged to carefully consider using young adults as peers and ensure that a high degree of support and supervision, including the need to maintain clear boundaries, is provided if young adults are hired to deliver peer support services.

The applicant must have a negotiated behavioral contract with teacher(s), parent(s), program staff and referral sources (Parole/Probation, Office of Children's Services, Division of Juvenile Justice etc.) This negotiated contract must detail the expected behaviors of all involved and becomes the mechanism for follow-up services.

Grantees are required to have a plan in place that describes how a grantee's behavioral health resources will be employed/deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

In addition to the specific requirements described above, grantees are required to meet the general requirements outlined in **All Substance Use Disorder Treatment Types – Excluding Detoxification Services,** found at the end of this document.

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Residential Services for Youth with Serious Emotional Disturbance - Program Type #4

Target population: This program is intended to target youth who meet the criteria for serious emotional disturbance and who need out-of-home therapeutic placement. Note: serving youth 18 and over in a youth residential care facility requires a variance from Health Care Services Certification and Licensing.

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 -7 AAC 70.990
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Core services and requirements:

Residential services are therapeutic, rehabilitative and support services provided out-of-home in a community-based residential setting. Facilities are licensed in accordance with, Residential Child Care Facility Licensing **7 AAC 50.005 - 7 AAC 50.990.**

All providers must meet the restraint and seclusion requirements in 42 CFR 483.350-483.376.

All providers must notify the division of critical incidents using the form on the DBH website.

Grant funds may support the following types of residential services:

Therapeutic Group Home These are services providing treatment and support in a home-like setting by specially trained foster parents. These homes have a maximum of three beds for children and provide 24 hour emergency support. Services include: case coordination with other community providers (schools, community mental health) and highly individualized treatment plans. Funds may also be used to locate and train foster parents.

Emergency Stabilization and Assessment Centers These centers provide services for youth whose behavioral problems put them in immediate danger in their present environment, who need short term, temporary placement, and may need stabilization and a thorough assessment of their needs.

Residential Treatment These programs provide treatment services in a 24-hour staffed setting for a medium to long-term (6-12 months) period of time. The purpose of residential care services is to remediate specific dysfunctions which have been explicitly identified. These services are provided to children in residential care settings to treat debilitating psychosocial, emotional and behavioral disorders. These services provide a therapeutic environment for children/youth that are unable to remain with their parent or guardian either due to abuse/neglect or to delinquency issues that are not amenable to placement with the family or origin.

Residential Diagnostic Treatment/Stabilization Residential Diagnostic Home These programs provide specialized treatment services for a subset of youth who present with a specific problem (e.g. sexual offending). The RDT is designed to provide comprehensive mental health and behavioral services to youth who are at high risk of out-of-state placement. Residents are considered to be in imminent need of institutional placement in a mental health facility in order to stabilize severely emotionally disturbed behaviors.

Additionally, grantees providing residential services must comply with the requirement to notify the Division of any instances in which a client is found to be missing, seriously injured, or deceased. This requirement applies to any facility operated by the grantee or closely affiliated with the grantee, including facilities with on-site staff, assisted living homes, supported living homes, residential treatment, group homes, and crisis respite facilities.

Youth Crisis Respite Services Designed to provide short-term sub-acute stabilization services and to evidence a decrease in Acute Care Placement. The services to youth-in-crisis for higher placements provide eight (8) crisis stabilization beds. There is also a single-point-of-entry for children's services: assessment, service coordination and placement in community stabilization and/or into acute care, as appropriate.

- **Target Population and Geographical area:**
  Youth in sub-acute crisis ages 10 to 18 and at risk of out-of-home placement. The beds will be in Anchorage and serve the entire state.

- **Services:**
  A multidisciplinary approach, providing a range of services including, but not limited to, short-term crisis stabilization services, and stabilization, psychiatric nursing and medication administration, 24-hour support, information and referral to community resources, and education, behavioral health screening and assessment, case management and therapeutic behavioral health services. Other specialized services include recipient support services, behavioral health treatment plan review and development, including a client status review, day treatment services, and daily behavioral rehabilitation services,

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Adult Residential Substance Use Disorder Treatment Services - Program Type #5

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 – 7 AAC 70.990 **Note: 7 AAC 70.120**
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services (especially note: 7 AAC 135.280.)

Target population: This program is intended to serve individuals aged 18 and older who present with dependence on, or chronic, disabling use/abuse of, alcohol or other drugs, including prescription and over the counter medications and household/general use products that can be abused as inhalants. Additionally, this program is intended to include the client's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. **Priority admissions** are required for pregnant injection drug users, pregnant women, injection drug users and women with children. Clients requiring this level of care referred from an Alcohol Safety Action Program, a Therapeutic Court, or Alaska Psychiatric Hospital are a priority for admission.

DHSS/BH will fund the following residential service types:

Level III.1: Clinically Managed Low Intensity Residential Services 7 AAC 70.120 (a-f) *(a minimum of five hours of clinical and rehabilitative services per week).* Examples are a halfway house or sober housing that offers at least five hours of rehab services. The primary goal of Level III.1 is to focus on a structured recovery environment that provides sufficient stability for the recipient. There is a heavy focus on ASAM Dimension's 5 and 6.

Level III.3: Clinically Managed Medium-Intensity Residential Services 7 AAC 70.120 (a-e; g) often known as extended or long-term care (*20 or more hours of clinical and rehabilitative services per week*). This level provides a structured recovery environment focusing on cognitive or functional impairment; severe deficits in interpersonal and coping skills, relapse preventing, overcoming lack of awareness about the effects of substance-related problems in their lives, and promoting eventual reintegration into the community.

Level III.5: Clinically Managed High-Intensity Residential Services 7 AAC 70.120 (a-e; h) (*20 or more hours of clinical and rehabilitation services per week)* This level of care is designed to treat persons who have significant social and psychological problems and may have multiple deficits which may include substance-related disorders, criminal activity, impaired functioning and disaffiliation from mainstream values. A global change in the recipient's lifestyle, attitude, and values is needed. Mental health professionals are suggested as part of the staff milieu.

Intensive Therapeutic Community programs shall provide each client ***a minimum of 20 hours of clinical services per week and 10 additional hours of peer driven activities***. Peer driven activities include: community meetings, house meetings, peer support activities, recreation, seminars, and self help groups. Ten hours of the clinical and/or peer driven activities shall be provided during the evening and weekend hours.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS/BH encourages grantees to employ evidence-based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS/BH recognizes that some effective treatment programs employ a variety of therapies and services that do not completely meet the definition of "evidence-based practices" to effectively meet the needs of individual clients.

Applicants should assure clients are medically cleared for admission and provide referrals for medical treatment as needed. Program orientation will be provided at the intake admission.

In addition to the specific requirements described above, grantees are required to meet the general requirements outlined in **All Substance Use Disorder Treatment Types – Excluding Detoxification Services,** found at the end of this document.

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Adult Residential and Housing Services for Seriously Mentally Ill Adults – Program Type #6

Prerequisites: Meet the requirements specific to the following Behavioral Health Regulations:

- 7 AAC 70.010 – 70.990
- 7 AAC 135.010 – 40 Medicaid Coverage: Behavioral Health Services

Target Population: A recipient is 21 years of age or older who meets of the criteria as defined in 7 AAC 70.990 (2) and**,**

- Due to their level of impairment requires services in community based housing that provides the following services based upon the recipients needs as defined in a Mental Health Assessment or Integrated Behavioral Health Assessment:
  - Individual and group Comprehensive Community Support Services;
  - Recipient Support Services;
  - Crisis Intervention and Crisis Stabilization Services;
  - Access to Psychiatric Assessment and Pharmacologic Management;
  - Access to Individual, Group and Family psychotherapy

Note: Psychiatric Assessment, Pharmacologic Management and Psychotherapeutic services may be provided by another Behavioral health provider with which the agency providing housing to the target population has an MOU. Adults who meet the above criteria for inclusion may have a co-occurring substance use disorder.

These services can be provided to an individual between the ages of 18 and 21

(A) Who except for age falls within the definition of an adult with SMI and
(B) Whom the provider has determined is best served by receiving behavioral health services for adults in the community.

In some instance the treatment team may decide that an SED youth between the ages of 18 and 21 would best be served in housing for adults with a serious mental illness, This may be due to the unique characteristics of the youth, the physical structure of the home allowing separation and /or clinical judgment that the youth would be safe, given the composition of the other residents in the home. In these instances the clear reason why the specific housing situation is appropriate for that youth should be documented in the clinical record, along with the approval of the placement by the youth's treatment team.

Service Requirements:

Recipients of this service must have access to all services for adults with serious mental illnesses. These services are part of a continuum of care, ranging from outpatient clinic-based services to wraparound home-based supportive services. *The type of service and level of care is determined by an assessment process, resulting in a treatment plan that addresses problems identified in the assessment.* Treatment planning is conducted in a collaborative manner with clients and has the goal of assisting clients to live successfully and safely in the community based housing provided.

At a minimum, the services identified in the list below must be provided by a grantee funded to provide outpatient SMI services. These services may be provided by a grantee other than the grantee providing housing.

- 24/7 emergency on-call/response capability for enrolled clients
- Client screening and assessment
- Individual, family and group psychotherapy
- Outreach and case-finding
- Psychosocial rehabilitative services, including case management, Community Support Services and Recipient Support Services
- Psychiatric services (MD, ANP)

The following include practices that DHSS/BH requires in order to meet the particular needs of clients with serious mental illness.

1. Grantees must provide an immediate response, either directly or through affiliated resources, to situations in which a client is likely to decompensate. Examples include: not appearing for a medication renewal appointment, losing meds, or eviction. Rapid response outreach services should be employed, but the grantee must also allow for client choice, to the extent practical in the manner of response and choice of responders.

2. Grantees must have policies and procedures in place that define the selection process by which adults who meet the criteria for the target population are chosen for participation in the housing program.

3. Adults with serious mental illness may not be excluded from treatment because they do not agree with, or do not follow, one or more parts of their treatment plan. Adjustments must be made to accommodate the person in the areas of the treatment plan they do follow, unless their situation becomes so unstable that inpatient care may be necessary.

4. Adults with serious mental illness may not be excluded who have a history of serious acting out behavior may not be excluded for the program unless the agency can demonstrate that an individual presents a danger to himself or others that cannot be mitigated by the use of recipient support services and other wrap around interventions.

5. Grantees must ensure that clients with substance abuse disorders can receive appropriate assessment and treatment; as far as is possible, the grantee should make every effort to integrate treatment for co-occurring disorders. This may entail having both kinds of treatment available on site, or at another site, in close collaboration with another treatment provider.

6. Grantees providing residential services must comply with the requirement to notify the Division of any instances in which a client is found to be missing, seriously injured, or deceased. This requirement applies to any facility operated by the grantee or closely affiliated with the grantee, including facilities with on-site staff, assisted living homes, supported living homes, residential treatment, group homes, and crisis respite facilities.

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Women and Children Residential Substance Use Disorder Treatment - Program Type #7

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 – 7 AAC 70.990 **Note: 7 AAC 70.120**
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services (especially note: 7 AAC 135.280.)

Target Population: This program is intended to serve women aged 18 and older who present with dependence on, or chronic, disabling use/abuse of, alcohol or other drugs, including prescription and over the counter medications and household/general use products that can be abused as inhalants. Children may accompany their mothers to treatment and participate as necessary in age appropriate activities. This program is intended to include the woman's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. **Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children.**

DHSS/BH will fund the following residential service types:

Level III.3: Clinically Managed Medium-Intensity Residential Services 7 AAC 70.120 (a-e; g), often known as extended or long-term care (*20 or more hours of clinical services per week*). This level provides a structured recovery environment focusing on cognitive or functional impairment; severe deficits in interpersonal and coping skills, relapse preventing, overcoming lack of awareness about the effects of substance-related problems in their lives, and promoting eventual reintegration into the community.

Level III.5: Clinically Managed High-Intensity Residential Services 7 AAC 70.120 (a-e; h), (*20 or more hours of clinical services per week)* This level of care is designed to treat persons who have significant social and psychological problems and may have multiple deficits which may include substance-related disorders, criminal activity, impaired functioning and disaffiliation from mainstream values. A global change in the recipient's lifestyle, attitude, and values is needed. Mental health professionals are needed.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS/BH encourages grantees to employ evidence-based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS/BH recognizes that some effective treatment programs employ a variety of therapies and services that do not completely meet the definition of "evidence-based practices" to effectively meet the needs of individual clients.

Applicants should assure clients are medically cleared for admission and provide referrals for medical treatment as needed. Program orientation will be provided at the intake admission.

* Clinic services:
    * Group and individual psychotherapy to address underlying psychological and behavioral health problems that contribute to SA, promoting self awareness, and behavioral change through interactions with peers;

* Rehabilitation Services:
    * Cognitive behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, role playing and modeling, or cognitively mediated behavior modification.
    * Specialty skills building groups organized around a common problem such as: anger management, parenting, domestic violence, stress reduction and gender specific issues
    * Individual, Group and Family education and counseling focused on functional improvement, recovery and relapse prevention Examples include Introduction to 12 step and community support groups (AA, NA, Smart Recovery, Double Trouble, etc. Note that actual meeting attendance is not an acceptable substitute for clinical or behavioral health rehabilitation services); Education and vocational groups; and curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).

Grantees are also responsible for adhering to the following requirements: Grantees are required to provide a range of services either directly or through linkages and/or case management to assist the client in accessing:

- Eligibility for public assistance programs;
- Primary medical care including: prenatal care
- Primary pediatric care for children including immunizations
- Child care and/or therapeutic day care (i.e. Head Start)
- Gender specific substance abuse treatment and other therapeutic interventions that may address: issues of relationships, sexual abuse, other trauma, and parenting
- Therapeutic interventions for children in custody of the women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse or neglect
- Supportive Employment and/or Vocational Training Services
- Educational support including GED preparation and completion
- Drug Free housing
- Sufficient case management and transportation services to ensure women and their children have access to the services provided above if not delivered on-site.

Grantees are required to have a plan in place that describes how a grantee's behavioral health resources will be employed/deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

In addition to the specific requirements described above, grantees are required to meet the general requirements outlined in **All Substance Use Disorder Treatment Types – Excluding Detoxification Services,** found at the end of this document.

DHSS Behavioral Health FY 2014 - 2016
Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

Outpatient Opioid Treatment Services - Program Type #8

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 – 7 AAC 70.990 **Note: 7 AAC 70.120**
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Opioid Treatment Program (OTP) services include the dispensing of methadone, a specialized opioid compound that psycho-pharmacologically occupies opiate receptors in the brain, extinguishing drug cravings and establishing a maintenance state.

Target Population: This program serves opioid dependent adults (18 years and older) and their families. Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users, and women with children.

DHSS/BH will fund the following outpatient Opioid Treatment Programs services:

Outpatient Level I: This treatment occurs in regularly scheduled sessions usually totaling ***fewer than 9 hours*** of therapeutic services per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Patients live at home, in supportive housing or residential treatment centers.

Outpatient Level II.1: Treatment consists of regularly scheduled sessions within a structured program, with ***a minimum of 9 hours*** of therapeutic services per week. Examples include day or evening programs in which patients attend a full spectrum of treatment programming but live at home or in supportive housing.

Opioid Treatment Program (OTP) clinical service definitions are described below:

- Group, individual and family psychotherapy to address underlying psychological and behavioral health problems that contribute to SA, promoting self awareness, and behavioral change through interactions with peers;
- Therapeutic behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, rational emotive therapy, role playing and modeling, or cognitively mediated behavior modification;
- Specialty groups (treatment groups organized around a common problem such as: anger management, parenting group, domestic violence, and stress reduction, gender specific group);
- Individual, group and family education and counseling focusing on functional improvement, recovery and relapse prevention; examples include Introduction to 12 step and community support groups (AA, NA, Smart Recovery, Double Trouble, etc) Actual meeting attendance is not an acceptable substitute for clinical services; education and vocational groups.
- Curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc).

DHSS Behavioral Health encourages grantees to employ evidenced based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS Behavioral Health recognizes that effective treatment programs employ a variety of therapies and services to effectively meet the needs of individual patients.

Core services and requirements:

- Screening and bio-psycho-social assessments;
- Medical clearance and referral to medical services as needed;
- Interim services for wait listed patients (onsite or by referral);
- Short-term Methadone Assisted Detoxification for a period not in excess of 30 days;
- Long-term Detoxification for a period more than 30 days but not in excess of 180 days;
- Methadone Maintenance Treatment providing pharmacotherapy in conjunction with a comprehensive range of appropriate medical and rehabilitative services;
- Medical Maintenance for patients who are no longer in need of comprehensive services, but need continuing pharmacotherapy;
- Program orientation and intake/admission;
- Individualized treatment planning and review;
- Individual counseling
- Group counseling and therapy;
- 24 hours crisis coverage for enrolled patients;
- Referrals and Case management;
- Recovery Support Services;
- Continuing Care for patients who are no longer in need of pharmacotherapy but remain in need of rehabilitative services;
- Linkage to recovery support groups and services;
- Direct Family involvement in treatment when deemed appropriate;
- Transition management and discharge planning.
- Linkage to community based support groups.

Grantees are also responsible for adhering to the following requirements:

1. Opioid Treatment Programs (OTP) must adhere to all rules, directives and procedures set forth in Title 42 Code of Federal Regulations (CFR), Part 8, titled "Opioid Drugs in Maintenance and Detoxification Treatment of Opiate Addiction."

2. Opioid Treatment Programs must have a current, valid certification from SAMHSA to dispense an opioid agonist treatment medication for the treatment of addiction.

3. Admission to an outpatient opioid treatment program will be based on a opioid dependence diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR), and criteria for placement in an outpatient level of care, as defined by the American Society of Addiction Medicine Patient Placement Criteria – 2, Revised (ASAM PPC-2R) and Opioid Maintenance Therapy (OMT).

4. Grantees must utilize the Alaska Prescription Monitoring Program (APMP) for all patients upon admission to treatment, annually and for cause throughout treatment. DBH

believes that utilizing the APMP database will assist OTPs in protecting patient health and safety, determining patient needs and treatment planning.

5. Treatment must be individualized and attend to the multiple needs of the patient beyond his or her drug use. Examples include issues around housing, employment, legal and/or medical problems.

6. Opioid Treatment Programs (OTP) shall report mortality data on patients who at the time of death were receiving methadone assisted treatment to the State Methadone Authority Designee within 24 hours of their being notified of the patient's death.

In addition to the specific requirements described above, grantees are required to meet the general requirements outlined in **All Substance Use Disorder Treatment Types – Excluding Detoxification Services,** found at the end of this document.

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Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

Outpatient Services for High Risk Children in Early Childhood and/or Youth with Serious Emotional Disturbance (SED) and their Families - Program Type #9

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 - 70.990
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Target population: A child under the age of 8 who has experienced two or more adverse childhood experiences as defined by the ACES study or a youth who meets the criteria as defined in 7 AAC 70.990 (10).

Treatment services are expected to focus on the entire family system, including ensuring that the behavioral health needs are met either by the grantee or through highly collaborative relationships with other agencies.

Core services and requirements:

Services for youth with serious emotional disturbance occur on a continuum of care that encompasses outpatient, home-based, school-based, and residential treatment, rehabilitation, and support services to the youth and family. The type of service and level of care is determined by an assessment process, resulting in a treatment plan that addresses problems identified in the assessment. Treatment planning is conducted in a collaborative manner and has the goal of assisting youth to live successfully in the community. At a minimum, the services identified in the list below must be provided by a grantee funded to provide outpatient SED services.

- 24/7 Emergency on-call response capability for enrolled clients.
- Client screening and assessment. Assessment should identify the needs of all family members and a plan to provide follow up assessments to other family members when a behavioral health issue is identified or to actively refer that family member for assessment by another agency.
- Individual, family and group psychotherapy
- Psycho-social rehabilitative services, including case management, family, group and individual therapeutic behavioral support services and recipient services as prescribed in a treatment plan based upon clinical assessment
- Psychiatric services (MD, ANP)

The following include practices that DHSS/BH requires in order to meet the particular needs of clients with serious emotional disturbance.

1. **Providers must have in place procedures to allow the immediate acceptance of a youth with serious emotional disturbance into treatment who already has a place to live and is being released from a hospital, jail, juvenile justice facility, or other institution.** Providers should develop procedures to ensure youth are seen by a clinician within 24 hours, and have access to a psychiatrist, physician, and physician's assistant or advanced nurse practitioner with prescriptive authority before any discharge medications have been exhausted. For youth who do not yet have an established place to live, the

grantee must have procedures in place to work with the institution on discharge planning and coordination, including assisting with the location of an appropriate living situation.

2. **For youth transitioning from early childhood mental health** services the agency is expected to utilize case management services to develop a plan that in cooperation with the early childhood services provider.

3. **For youth nearing the point that they will "age out" of SED services,** the grantee must have transition plans in place to move them to adult treatment and rehabilitation services, or appropriately discharge them from services. If the youth has been receiving intensive services, the transition plan must include provisions to "step down" the service level if the adult treatment system does not provide the same level of intensive services, or if the plan is to discharge the youth.

4. **Providers are expected to consider the entire family system** when assessing a child or youth and to either provide assessment and services, or refer assessment and services when emotional or behavioral disturbances are suspect in family members. If services to other family members are to be provided by another agency, the provider of services to the SED youth is expected to coordinate services to the fullest extent possible in a manner that respects each members wishes regarding confidentiality.

Early Childhood and Family Services for Children aged 0-5.

Overall Goal: Work with parents and resource families to enhance their ability to keep young children experiencing severe emotional and behavioral problems in their preschool, Head Start/Pre-K and home settings.

Required Components:

1. Behavioral Health Services including assessment, treatment planning & referral.
2. Referral to & from EPSDT screens.
3. In-Home Services & Family Driven Care
4. Partnerships & Linkage with Community Resources to Access Services and Expertise
5. Outcomes Tracking.
6. Develop culturally competent strategies which are family driven to support children remaining in or returning to their homes, families and communities rather than moving into more restrictive out of home settings.
7. Maximize utilization of community resources to enhance the system of care in a region or community.
8. Develop new family-focused treatment capacity and/or resources for children and families with particularly challenging clinical presentations or co-occurring disorders.
9. Demonstrate effective service models through tracking referral, utilization, demographic and clinical information and monitoring project outcomes.
10. Identify/develop/document Alaska specific best practices or implement evidence based projects through technical assistance, training, outcomes management and continuing quality improvement strategies.
11. Decrease the utilization of out of home care; particularly out-of-state care, for Alaskan children and youth experiencing severe emotional disturbances (SED).

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Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

Youth and Family Outpatient Substance Use Disorder Treatment - Program Type #10

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 - 70.990
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Target Population: The program is intended to serve youth who have not attained the age of nineteen years. However, consistent with the regulations for youth with a severe emotional disturbance, youth between the ages of 19 and 21 can be served in either adult or youth outpatient substance abuse program types based upon the needs to the youth. For youth in this age range (19 - 21) there should be a clear statement in the youth's assessment indicating the rationale for serving them in either the youth or adult outpatient setting. Youth served in this program have been assessed as abusing, or dependent on alcohol or other drugs, including inhalants, prescribed, and over-the-counter medications. Priority admissions are required for pregnant/post-partum women, injection drug users, women with children and referrals from the Office of Children's Services, Department of Juvenile Justice/foster care (Excludes youth incarcerated in DJJ facilities)
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DHSS/BH will fund the following outpatient service types:

Outpatient Level I: This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Clients live at home or in supportive housing.

Outpatient Level II.1: Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.

Outpatient Level II.5: (Partial Hospitalization) programs generally feature *20 or more hours* of clinically intensive programming per week as specified in the client's treatment plan. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS Behavioral Health encourages grantees to employ evidence-based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS Behavioral Health recognizes that effective treatment programs employ a variety of therapies and services to meet the needs of individual clients.

Core services and requirements:

- Screening and bio-psychosocial assessments that include developmental history; including pregnancy and delivery, developmental milestones, and temperament;
- Family assessments that include family social history, OCS involvement and relocations;
- Medical clearance for no evidence of communicable disease and referral for medical treatment as needed;
- Interim services for wait listed clients (onsite or by referral);
- Program orientation and intake/admission;
- Individualized treatment planning and review;
- Individual counseling;
- Group counseling and therapy;
- 24 hour crisis coverage for enrolled clients
- Referrals and case management;
- Recovery support services;
- Continuing Care;
- Direct family involvement in treatment and family support services;
- Transition management and discharge planning;
- Linkage to community based support groups.
- Agencies are encouraged, but not required, to explore the use of Peer Support Services delivered by parents of youth who have experience in supporting the recovery to their children is encouraged. However, research indicates that young adults in recovery do not have sufficient maturity, time in recovery or life experiences to be effective. Consequently, agencies are urged to carefully consider using young adults as peers and ensure that a high degree of support and supervision, including the need to maintain clear boundaries, is provided if young adults are hired to deliver peer support services.

Grantees are also responsible for adhering to the following requirements:

The applicant must have a negotiated behavioral contract with teacher(s), parent(s), program staff and referral sources (Parole/Probation, Office of Children's Services, etc.) This negotiated contract must detail the expected behaviors of all involved and becomes the mechanism for follow-up services.

Grantees are required to have a Disaster/Emergency Response Plan in place that describes how a grantee's behavioral health resources will be employed/deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.

In addition to the specific requirements described above, grantees are required to meet the general requirements outlined in **All Substance Use Disorder Treatment Types – Excluding Detoxification Services,** found at the end of this document.

Outpatient Treatment for Adults with Serious Mental Illness - Program Type #11

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 - 70.990
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Target population: An adult 21 years or older qualifies as seriously mentally ill (SMI) by meeting definition in 7 AAC 70-990 (2).

Core services and requirements:

Services for adults with serious mental illnesses occur on a continuum of care, ranging from outpatient clinic-based services to wraparound home-based supportive services. The type of service and level of care is determined by an assessment process, resulting in a treatment plan that addresses problems identified in the assessment. Treatment planning is conducted in a collaborative manner with clients and has the goal of assisting clients to live successfully in the community. At a minimum, the services identified in the list below must be provided by a grantee funded to provide outpatient SMI services.

- 24/7 emergency on-call/response capability for enrolled clients
- Client screening and assessment
- Individual, family and group psychotherapy
- Outreach and case-finding
- Psychosocial rehabilitative services, including case management, Community Support Services and Recipient Support Services
- Psychiatric services (MD, ANP)

The following include practices that DHSS/BH requires in order to meet the particular needs of clients with serious mental illness.

1. Grantees funded to provide outpatient treatment to adults with serious mental illness must provide an immediate response, either directly or through affiliated resources, to situations in which a client is likely to decompensate. Examples include: not attending initial appointment post-institutional discharge, not appearing for a medication renewal appointment, losing meds, or eviction. Rapid response outreach services should be employed, but the grantee must also allow for client choice, to the extent practical in the manner of response and choice of responders.

2. Grantees must have procedures in place to allow the immediate acceptance of an adult with serious mental illness into treatment that is being released from a hospital, jail, or other institution. The person should be seen by a clinician within 7 days, and have access to a psychiatrist, physician, physician's assistant, or advanced nurse practitioner with prescriptive authority before any discharge medications have been exhausted.

3. Adults with serious mental illness may not be excluded from treatment because they do not agree with, or do not follow, one or more parts of their treatment plan. Adjustments

must be made to accommodate the person in the areas of the treatment plan they do follow, unless their situation becomes so unstable that inpatient care may be necessary.

4. Adults with serious mental illness may not be excluded from treatment because they have a history of being dangerous to others. Examples include histories of assault, arson, or sexual offending. The grantee will make adjustments in the delivery of services that provide for the safety of the person, the staff and other clients. The grantee may not refuse to serve a client with a history of dangerous behavior, unless the agency can demonstrate to the Division an imminent risk that cannot be compensated for. If that risk is present, the grantee must arrange for alternate services.

5. Grantees must make efforts to "find" cases, either by providing outreach to the community or by establishing referral relationships with other local organizations.

6. Grantees must ensure that clients with substance abuse disorders can receive appropriate assessment and treatment; as far as is possible, the grantee should make every effort to integrate treatment for co-occurring disorders. This may entail having both kinds of treatment available on site, or at another site, in close collaboration with another treatment provider.

7. Grantees providing residential services must comply with the requirement to notify the Division of any instances in which a client is found to be missing, seriously injured, or deceased. This requirement applies to any facility operated by the grantee or closely affiliated with the grantee, including facilities with on-site staff, assisted living homes, supported living homes, residential treatment, group homes, and crisis respite facilities.

8. Grantees providing services to this population must respond within 48 hours to a DBH request for a Level II assessment under the Preadmission Screening and Resident Review Program (PASRR). This State program, required by Federal law, provides screening to determine whether placement in a skilled nursing facility is appropriate when the individual has a serious mental illness. Grantees must use the assessment form provided by DBH and may also bill the Division for this service.

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Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

Adult Outpatient Substance Use Disorder Treatment - Program Type #12

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 - 70.990
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Target population: This program is intended to serve individuals aged 18 and older who present with dependence on, or chronic, disabling use/abuse of, alcohol or other drugs, including prescription and over the counter medications and household/general use products that can be abused as inhalants. Additionally, this program is intended to include the patient's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children.

DHSS/BH will fund the following outpatient service types:

Outpatient Level I: This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 contact hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Clients live at home or in supportive housing.

Outpatient Level II.1: Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 treatment hours per week. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.

Outpatient Level II.5: (Partial Hospitalization) programs generally feature *20 or more hours* of clinically intensive programming per week as specified in the client's treatment plan. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

Applicants seeking to provide a cohort model must demonstrate in their DHSS/BH grant proposal how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidence based research and/or previous program evaluation results.

DHSS Behavioral Health encourages grantees to employ evidence-based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS Behavioral Health recognizes that effective treatment programs employ a variety of therapies and services to meet the needs of individual clients.

Agencies providing services to clients involved with the Department of Corrections are asked to review, sign, and submit with their application the DOC agreement found in Attachment 11.
In addition to the specific requirements described above, grantees are required to meet the general requirements outlined in **All Substance Use Disorder Treatment Types – Excluding Detoxification Services,** found at the end of this document.

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Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

Women and Children Outpatient Substance Use Disorder Treatment - Program Type #13

Prerequisites: Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 - 70.990
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Target Population: This program is intended to serve women aged 18 and older who present with dependence on, or chronic, disabling use/abuse of, alcohol or other drugs, including prescription and over the counter medications and household/general use products that can be abused as inhalants. This program is intended to include the woman's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. **Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children.**

Admission to outpatient substance abuse treatment services will be based on a substance abuse diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM IV-TR), and criteria for placement in a outpatient level of care, as defined by the American Society of Addiction Medicine Patient Placement Criteria – 2, Revised (ASAM PPC-2R).

Grantees must ensure that clients with mental health disorders can receive appropriate assessments and treatment; as much as is reasonably possible, the grantee must make every effort to integrate treatment for co-occurring disorders.

DHSS/BH will fund the following Outpatient service types:

Outpatient Level I: This treatment occurs in regularly scheduled sessions usually totaling fewer than 9 hours of clinical services per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Clients live at home or in supportive housing.

Outpatient Level II.I: Treatment consists of regularly scheduled sessions within a structured program, with a minimum of 9 hours of clinical services per week. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.

Outpatient Level II.5: (Partial Hospitalization) programs generally feature *20 or more hours* of clinically intensive programming per week as specified in the client's treatment plan. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

DHSS/BH **will not fund** cohort groups with grant funding or with the revenues generated by the DHSS/BH grant without an approved waiver. Programs applying for a waiver from this policy must demonstrate in their DHSS/BH grant continuation how the cohort model is the most effective treatment modality for their target population and provide supporting documentation i.e.: evidenced based research and/or previous program evaluation results.

- Clinic Services:
  - Group, Individual and, Family when indicated, to address underlying psychological and behavioral health problems that contribute to SA, promoting self awareness, and behavioral change through interactions with peers;

- Community Support Services including:
  - Cognitive behavioral social learning models emphasizing interventions that assist the individual in changing self-defeating beliefs and values, problem solving, interpersonal skills training, role playing and modeling, or cognitively mediated behavior modification Specialty skills building groups organized around a common problem such as: anger management, parenting, domestic violence, stress reduction and gender specific issues);
  - Individual, Group and, when indicated family education and counseling focused on functional improvement, recovery and relapse prevention Examples include Introduction to 12 step and community support groups (AA, NA, Smart Recovery, Double Trouble, etc. Note that actual meeting attendance is not an acceptable substitute for clinical or behavioral health rehabilitation services); education and vocational groups; and
  - Curriculum based psycho-education groups (basic alcohol and drug education, relapse prevention, recovery, nutrition and infectious diseases, etc.).
  - Assist client in accessing child care during treatment activities;
  - Linkage to community based support groups;

DHSS Behavioral Health encourages grantees to employ evidence-based practices in their treatment programs. Examples include Relapse Prevention, Motivational Enhancement Therapy, Medication-Assisted Therapy, and Supportive-Expressive Therapy. However, DHSS Behavioral Health recognizes that effective treatment programs employ a variety of therapies and services to meet the needs of individual clients.

Grantees are also responsible for adhering to the following requirements:

Grantees will provide or assist the client in accessing:

- Primary medical care including: prenatal care, and while women are receiving treatment services, child care.
- Primary pediatric care for children including immunizations
- Gender specific substance abuse treatment and other therapeutic interventions that may address: issues of relationships, sexual and sexual abuse, and parenting
- Therapeutic interventions for children in custody of the women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse or neglect
- Sufficient case management and transportation services to ensure that women and their children have access to the services provided above if not delivered on-site

In addition to the specific requirements described above, grantees are required to meet the general requirements outlined in **All Substance Use Disorder Treatment Types – Excluding Detoxification Services,** found at the end of this document.

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Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

Peer and Consumer Support Services - Program Type #15

The following prerequisites only apply if the applicant is providing treatment services:
Meets the requirements, specific to the following Behavioral Health regulations:

- 7 AAC 70.030 - 70.990
- 7 AAC 135.010-40 Medicaid Coverage; Behavioral Health Services

Over half the states in the nation recognize Peer Support persons as an integral part of the states' treatment system as evidenced by their ability under certain circumstances to bill Medicaid for peer support for Medicaid recipients. The State of Alaska's Integrated Behavioral Health Regulations, effective December 2011, provide for peer support services. See 7 AAC 135.210.

The division seeks to fund Peer and Consumer Support Services programs that are peer focused and provide supportive services, not treatment. Services that can be provided are supportive services to individuals regardless of their Medicaid eligibility or the clinical and/or rehabilitation services provided by the agency applicant.

The Recovery Movement is increasingly focusing on both mental health and substance use disorders. The Substance Abuse and Mental Health Services Administration (SAMHSA) defines recovery as: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential".

The Peer Support Movement continues to remind us of the importance of peer support in the recovery process. A Peer (Recovery) Support person is an individual who has progressed in his/her own recovery from alcohol or other drug abuse or mental disorder and is willing to self-identify as a peer and work to assist other individuals with chemical dependency and/or a mental disorder. Because of their life experience, such persons have expertise that professional training cannot replicate.

Peer support services are provided in a deliberate and organized way that maximizes the diversity of consumers, grass-roots nature, supportive and practical nature of the services. Peer support staff members must maintain frequent in-person or telephonic contact with the recipient in order to provide support and participate in group activities, and must be:

- Competent to provide peer support services by virtue of having experienced behavioral health issues in their life or their family.
- Able to maintain frequent in-person or telephonic contact with their peer support group and individuals in order to provide support and participate in group activities.
- Able to perform a wide range of tasks to assist consumers in regaining control over their own lives and over their own recovery process.

Peer support work may include such things as:

- peers on crisis teams or staffing warm hand-offs
- peers supporting people while they are on wait lists for clinical services (clinical, etc)
- peers doing group work (e.g. recovery, WRAP, double trouble in recovery, etc)
- peers supporting people in emergency rooms

- peers providing support and safety-related services while someone attempts to stabilize in the community instead of immediate admission to API
- peers working with people in the corrections/justice system
- peers providing job coaching and employment supports
- peers providing housing supports to prevent homelessness
- peer support services for individuals not eligible for Medicaid

DHSS Behavioral Health FY 2014 - 2016
Comprehensive Behavioral Health Treatment and Recovery Grants - Program Types

All Substance Use Disorder Treatment Types – Excluding Detoxification Services

These programs are intended to serve individuals who present with dependence on, or chronic disabling use/abuse of alcohol or other drugs, including prescription and over the counter medications, and household/general use products that can be abused as inhalants. Additionally, these programs are intended to include the client's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. Priority admissions are required for pregnant drug users, pregnant women, injection drug users, and women with children.

In addition to the requirements detailed under the specific program type, agencies are required to meet the general requirements detailed below:

1. Grantee will currently meet the requirements under AAC 70. 100-260 and maintain compliance throughout the grant period. Failure to meet the State Standards may result in grant suspension and disqualification for future funding.

2. Current Activity Schedule. Grantees providing substance use disorder services will have a current treatment activity schedule that provides an amount of active treatment that is consistent with the program's stated ASAM level of Care and the standards as outlined in 7 AAC 70.120

3. Grantees are required to provide services that help families understand addiction and support the newly recovering family members. Examples include evening family process groups, education groups, presentations by Al-Anon speakers, etc. Involving key members of the client's support network in treatment leads to more positive outcomes.

4. Grantees will establish and maintain a waiting list of persons seeking treatment who cannot be admitted due to space or staffing constraints. The waiting list must comply with DHSS/BH's waiting list protocols, as established in AKAIMS, including a unique identifier for Injection Drug Users (IDU's). IDU's requesting treatment must be admitted no later than 14 days after the request. If there is no slot available IDU's must be provided with interim services within 48 hours and admitted no later than 120 days after the initial request.

5. Interim services provided to individuals on the wait list, can be provided by the program or another agency. Documentation should include:
    - Counseling/education about HIV and TB that includes risks of needle sharing, transmission to sexual partners and infants, methods of risk avoidance and reduction.
    - Referral for HIV and TB testing and treatment.
    - Interim methadone maintenance as authorized by federal regulations;
    - Counseling on FASD and Fetal Drug Effects (FDE) for all applicants who are pregnant women.

6. Grantees must ensure that clients with mental health disorders can receive appropriate assessments and treatment; as much as is reasonably possible, the grantee must make every effort to integrate treatment for co-occurring disorders. This may entail having both kinds of treatment available either on site or in close collaboration with another treatment provider.

7. Treatment must be individualized and attend to the multiple needs of the client beyond his or her drug use. Examples include issues around housing, employment, legal and/or medical problems.

8. Possible alcohol or other drug use while in treatment should be constantly monitored. Urinalysis and other tests are an effective way to help clients resist the urge to use. These tests also help providers detect lapses and make appropriate modifications to treatment plans and interventions as necessary.

9. Programs must have procedures for responding to clients who relapse while in treatment. These may include referral to a different level of care or different strategies and frequency of treatment interventions. The focus of these procedures should be on assisting the client to progress toward the completion of treatment goals.

10. When appropriate, grantees should attempt to make Medication-Assisted Treatment (MAT) available to clients both while they are in treatment and after they are released to their home communities (i.e. Antabuse, Naltrexone, or Buprenorphine).

11. Treatment programs are required to have staff members trained to provide HIV/AIDS, Hepatitis B and C, Tuberculosis (TB) and FASD risk assessment, client education, early intervention, and risk reduction counseling. All clients must receive these services.

12. HIV/AIDS, Hepatitis B and C, Tuberculosis (TB) and FASD screening and risk reduction counseling are to be addressed in policies and procedures related to infection control, client rights, treatment protocols, and occupation health and safety**.**

13. Grantees must utilize the Alaska Prescription Monitoring Program (APMP) for all patients upon admission to treatment and for cause throughout treatment. DBH believes that utilizing the APMP database will assist in protecting patient health and safety, determining patient needs and treatment planning.

14. Grantees shall not provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Disaster/Emergency Response Plan Grantees are required to have a plan in place that describes how a grantee's behavioral health resources will be employed/deployed in a local or service-area-wide natural or man-made disaster. The plan should address agency procedures for notifying staff, DBH, patients and family members following a disaster, as well as the role staff will assume in providing counseling services to patients.