Section: Clinical Issues
Policy: Clinical Abbreviations and Terminology
Policy No: CI 01
Effective: 01/01/1995
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services to use approved abbreviations and symbols when formulating progress notes, treatment and medication instructions and other written directives.

PURPOSE: To standardize all abbreviations or symbols used by CCS so there is a clear definition of each abbreviation or symbol.

PROCEDURE: All abbreviations or symbols that are used by CCS will appear on the alphabetical listing below. If the abbreviation or symbol is not on this list, it will not be used.

CLINICAL ABBREVIATIONS AND SYMBOLS

AA . . . . . .Alcoholics Anonymous

AEB . . . . . .As evidenced by

a.c. . . . . .Before meals

A&D . . . . . .Alcohol and Drug

Ad lib. . . . . As desired

ADHD. . . . . .Attention Deficit/Hyperactivity Disorder

ADL. . . . . .Activities of daily living

ABCL. . . . . .Adult Behavior Checklist

AIDS. . . . . .Acquired immune deficiency syndrome

a.m . . . . . .Before noon

amb. . . . . .Ambulatory

ASA. . . . . .Acetylsalicylic acid

b/c. . . . . .Because

b.i.d.. . . . . .Twice a day

B.I.R.. . . . . .Behavior--Intervention--Response

BM. . . . . .Bowel movement

B.O.T.. . . . . .Back On Track

BPD. . . . . .Borderline Personality Disorder

BPRS. . . . . Brief Psychiatric Rating Scale

BUN. . . . . .Blood, urea, nitrogen
BADAS. . . . . Bureau of Alcohol and Drug Addiction Services
B/M. . . . . .Black male
B/F. . . . . .Black female

c. . . . . With
CA. . . . . .County Administrator
CBCL. . . . . .Child Behavior Checklist
CC. . . . . .Cubic centimeter
CCO. . . . . Chancery Court Order
CCS. . . . . .Community Counseling Services
CHG. . . . . Change
CMHC. . . . . Community Mental Health Center
CNS. . . . . .Central nervous system
CSS. . . . . .Community Support Specialist/Community Support Services
Co. . . . . .County
C/O. . . . . .Complains of
conc. . . . . .Concentrate
cont. . . . . .Continue
CPI. . . . . Crisis Prevention Institute
CPR. . . . . .Cardiopulmonary resuscitation
CXR. . . . . .Chest X-ray
CMHT. . . . . Certified Mental Health Therapist
CIDDT. . . . . .Certified Intellectual & Developmental Disabilities Therapist
CCSS. . . . . .Certified Community Support Specialist
CPSSP . . . . . .Certified Peer Support Specialist Professional

/d. . . . . Per day
d/c . . . . . Discontinue
dec. . . . . .Decanoate
DID. . . . . Dissociative Identity Disorder
DMH. . . . . Department of Mental Health
DSM-5. . . . . Diagnostic and Statistical Manual, 5th Edition

D/O. . . . . .Disorder
DOB. . . . . .Date of Birth
DT's. . . . . Delirium tremens
Dx. . . . . Diagnosis

EAP. . . . . Employee Assistance Program
ECT. . . . . Electroconvulsive therapy
EEG. . . . . Electroencephalogram
EENT. . . . . Eyes, ears, nose, and throat
EMSH. . . . . .East Mississippi State Hospital
ETOH. . . . . Ethyl alcohol

F/U. . . . . Follow-up
Fm. Th.. . . . . .Family Therapy

G.H.. . . . . .Group home
gp. . . . . Group
Gp. Th. . . . . .Group Therapy
gt. . . . . Drop
gtt. . . . . Drops

HEENT. . . . . ..Head, eyes, ears, nose, and throat
h/o . . . . . .History of
HOB. . . . . Head of bed
hr. . . . . Hour
hs. . . . . At bedtime (hour of sleep)
ht. . . . . Height
HTN. . . . . Hypertension
Hx. . . . . .History

IDD. . . . . .Intellectual/Developmental Disabilities
ID/DD. . . . . .Individual with Intellectual and Development Disabilities
IEP. . . . . .Individual Education Plan

IM. . . . . Intramuscular
Ind. . . . . Individual
Ind. Th. . . . . Individual Therapy
ICSS. . . . . Intensive Community Support Specialist
IOP. . . . . Intensive Outpatient Program
IP. . . . . .Inpatient
IQ. . . . . Intelligence quotient
ISP. . . . . .Individual Service Plan
IV. . . . . Intravenous

lb. . . . . Pound
LMP. . . . . .Late menstrual period
LOS. . . . . .Length of stay
LPC. . . . . .Licensed Professional Counselor
LSW. . . . . Licensed Social Worker
LCSW. . . . . Licensed Clinical Social Worker

MCMI. . . . . Million Clinical Multiaxial Inventory
med. . . . . .Medicine
mg. . . . . .Milligram(s)
MH. . . . . Mental health
ml. . . . . Milliliter(s)
min. . . . . Minute
MMPI. . . . . .Minnesota Multiphasic Personality Inventory
MOM. . . . . .Milk of magnesia
MSE. . . . . Mental status examination
MSH. . . . . Mississippi State Hospital

N/A. . . . . .Not applicable
NA. . . . . .Narcotics Anonymous
NAMI. . . . . .National Alliance for the Mentally Ill
NOCHG. . . . . .No Change
NOS. . . . . Not otherwise specified

NPO. . . . . Nothing by mouth
NKA. . . . . No known allergies
NKDA. . . . . No known drug allergies

Px . . . . . Prognosis

0. . . . . Oxygen
OABCL. . . . . Older Adult Behavior Checklist
OCD. . . . . Obsessive-Compulsive Disorder
OD. . . . . Right eye
ODD. . . . . Oppositional Defiant Disorder
OP. . . . . Outpatient
OS. . . . . Left eye
oz. . . . . Ounce

p. . . . . .After
p.c.. . . . . .After meals
PERLA. . . . . Pupils equal, reactive to light and accommodation
p.m. . . . . After noon
p.o.. . . . . By mouth
prn. . . . . As needed
PSR. . . . . Psychosocial Rehabilitation
pt. . . . . Patient
PTSD. . . . . Posttraumatic Stress Disorder
PCAT. . . . . Provisional Certified Addictions Therapist
PCMHT. . . . . .Provisionally Certified Mental Health Therapist
PCIDDT. . . . . .Provisionally Certified Intellectual & Developmental Disabilities Therapist
PCCSS. . . . . .Provisionally Certified Community Support Specialist
PSS. . . . . Peer Support Services/Plan of Services and Supprts

q. . . . . .Every
q.a.m. . . . . Every morning
q.d.. . . . . .Once a day

q.h.. . . . . .Every hour
q.i.d.. . . . . .Four times a day
q.o.d.. . . . . Every other day
q.s. . . . . Sufficient quantities
R/O. . . . . Rule out
R/S. . . . . .Reschedule
R/T. . . . . .Related to
RTC. . . . . Residential Treatment Center
Rx. . . . . Prescription

s. . . . . Without
SED. . . . . Serious Emotional Disturbance (children)
SMI. . . . . .Serious Mental Illness
SPMI. . . . . .Serious Persistent Mental Illness
ss. . . . . One-half
SSBG. . . . . Social Services Block Grant
SSDI. . . . . .Social Security Disability Income
SSI. . . . . .Supplemental Security Income
stat. . . . . At once or immediately
STD. . . . . .Sexually transmitted disease
Std. . . . . Standard
sx . . . . . Symptoms

tab. . . . . Tablet
TB. . . . . Tuberculosis
TCM. . . . . Targeted Case Management/Manager
Th . . . . . Therapist
t.i.d.. . . . . Three times a day
TO. . . . . .Telephone order
TSP. . . . . .Teaspoon
Tx. . . . . .Treatment

UA. . . . . .Urinalysis

URI. . . . . Upper respiratory infection
UTI. . . . . Urinary tract infection

VO. . . . . Verbal order
VS. . . . . Vital signs
vs. . . . . Versus

w/. . . . . .With
WAIS-R. . . . . Wechsler Adult Intelligence Scale, Revised
W/C. . . . . Wheelchair
WISC-R. . . . . Wechsler Intelligence Scale for Children, Revised
W/F. . . . . .White female
W/M. . . . . White male
WNL. . . . . .Within normal limits
Wt. . . . . Weight

x. . . . . .Times

y/o. . . . . .Year old
yr. . . . . .Year

Section: Clinical Issues
Policy: Service Termination/Provider Discharge
Policy No: CI 02
Effective: 02/02/1995
Revised/Approved: 007/27/2021

POLICY: For the purpose of this policy, discharge and termination are two unique terms and actions. **Termination** is the action utilized and documented to discontinue a service and/or program. **Discharge** is the action utilized and documented to signify that a person is no longer receiving services through Community Counseling Services (CCS). It is the policy of CCS that service termination/provider discharge planning begins the day of intake or re-admission and is established while developing the individual service plan (ISP).

PURPOSE: To ensure people are receiving appropriate services and can be transferred to other services when clinically indicated. To develop a discharge plan within the ISP that is based upon resolution of problems which have been identified during the assessment of the person receiving services.

PROCEDURE: Service termination/provider discharge goals are established while developing the ISP in accordance with the clinical assessments, the goals of the person receiving services, and CCS service termination/provider discharge criteria. At any time these goals can be amended as necessary. This includes the development of a Discharge/Criteria Plan during the intake process. Addendums to the plan will be made based on progress or lack of progress to stated objectives identified on the ISP.

Upon service termination/provider discharge, instructions will be given to the person receiving services and documented in the medical record. These instructions will be included in the medical record. A Service Termination/Change form must be completed at the time a person receiving services is being transferred to another program/service or is no longer going to receiving a particular service. Once completed, the form will be forwarded to the medical records department for inclusion will be included in the medical record. A Provider Discharge form must be fully completed at the time of provider discharge. Once completed, the form will be included in the medical record. All Provider Discharge forms must be submitted to the County Administrator/Director for review/approval to verify there are no other services that are continuing to be received and to ensure all members of the treatment team are notified.

Upon completion of the Service Termination/Change Form or the Provider Discharge Form, the following must be indicated: a) reason(s) for discharge\termination, b) assessment of progress toward objectives contained in the individual plan, c) discharge instructions given to the person who received services or their authorized representative, parent(s)/legal representative(s), including referrals made, and d) any other information deemed appropriate to address the needs of the person being discharged/transferred from the program.

Mississippi Operational Standards addressed: Rule 16.3A-D

Section: Clinical Issues
Policy: Documentation
Policy No.: CI 03
Effective: 02/17/1995
Revised/Approved: 07/27/2021

POLICY: It is the policy of Community Counseling Services that all activities/services provided to people receiving services, as well as, changes to information regarding people receiving services will be documented in the medical record.

PURPOSE: To ensure that the charting reflects behaviors related to problems and interventions as identified in the individual service plan, as well as, the response of the person receiving services to the intervention and the individual service plan. To ensure that the medical record reflects accurately all services provided.

PROCEDURE: All entries in the medical records must be dated and signed by the person making the entry. The signature shall include the credentials of the staff member. The case number, name of the person receiving services, date, service location, type of service being rendered, number of minutes, and the length of time spent in providing the service will be reflected.

Documentation of service delivery: Documentation in the medical record utilizing service specific progress notes or IDD service notes will relate to the movement of the person receiving services toward the objectives of the individual service plan, recovery support plan, or Activity Support Plan by utilizing the **S-A-P** format. The **S-A-P** format is designed to provide consistency with Department of Mental Health (DMH) criteria for progress/activity notes as outlined in DMH Operational Standards and DMH Record Guide. **S-A-P stands for Summary/Assessment/Plan**. A progress note must contain the following elements:

- A summary of the activities related to the service being provided of the contact
- An assessment of the progress made toward goals and objectives of the Individual Service Plan, Activity Support Plan, or Recovery Support Plan
- A statement of immediate plans for future activities related to the service being provided

The **S-A-P** format incorporates these elements as follows:

S-SUMMARY: A summary of the activities related to the service being provided: Included here is the purpose of the contact, a description of the problems addressed, a description of the setting (if significant), any significant appearance/behavior of the person receiving services, a description of what happened during the contact, including staff interventions and responses of the person receiving services. Therapeutic activities provided on behalf of the person receiving services must be documented. This summary should indicate that the contact was:

- Clinically appropriate and consistent with strategies outlined on the individual service plan, recovery support plan, or activity support plan.
- An appropriate, reimbursable service.
- Consistent with the length of time stated in the heading.

When preparing to write the summary, the service provider should ask:

- What happened?
- What did the person receiving services actually do and say?
- What did the service provider actually do while trying to help/assist the person receiving services? The services provider shall make sure to use descriptive language rather than judgmental language.

A-ASSESSMENT: An assessment of the progress (or lack of progress) toward objectives of the plan: In this section the note gets tied back to the individual service plan, activity support plan, or recovery support plan. The service provider shall identify an objective on the plan that he/she and the person receiving services were working on during this contact and describe how this contact helped the person move toward it. How is the person different from the last contact? The service provider must involve the person receiving services by asking him/her how he/she thinks he/she is doing relative to his/her objectives. The service provider needs to be specific. General statements like, "Person is making good progress toward objectives" is insufficient. If the service provider uses a one- or two-word assessment like "Good progress" or "Satisfactory", a brief statement should be added stating why the service provider thinks the progress is "good" or "satisfactory". Statements need to be accurate. If there is no progress, the service provider shall indicate in the note "No progress toward objectives noted." When the service provider gets ready to write this section, he/she should ask:

- What goal or objective was the service provider and person receiving services working on?
- How did what was done help (or not help) the person move toward one or more of his/her goals?

P-PLAN: A statement of immediate plans for future therapeutic activities: This should include the next anticipated contact with the person and any planned therapeutic activities of the person or the service provider in the interim. Sometimes both the person receiving services and the service provider will have things to do before the next session; these things should be noted in this section. When the service provider gets ready to write this section, he/she should ask:

- What happens next?
- When is the next scheduled contact?
- What is the person receiving services supposed to do between now and then?
- What is the service provider supposed to do between now and then?

General information: The medical record must not contain the name of any person receiving services other than that of the individual for whom the record is maintained. Case numbers of other people receiving services may be used. Only abbreviations that appear in CCS Policy #CI 01, Clinical Abbreviations and Symbols are to be used.
All documentation in the medical record for outpatient services will be completed as soon as possible after the delivery of service, but no later than the end of the business day in which the service was rendered.

Legibility: Legibility is essential. Staff members who have difficulty writing legibly should type their notes/entries.

Corrections: Corrections in the medical record should be made by drawing one line through the error. The error is not to be completely marked over by scribbling. Beside the error, “error" shall be written, along with the date, the initials of the individual making the correction, and the correct information. Liquid paper is not used in the medical record. In the EHR, incorrect entries must be invalidated and the submitted in the correct client record.

Late entries: Late entries to the record should be avoided. However, late entries must also be documented. It is the responsibility of the medical records staff to ensure that late entries are documented as soon as possible. Every late entry must be identified as a “late entry”. The date and time when the entry is actually being made must be included. Events described in the late entry must include the actual date and time (if available) that the event(s) occurred.

Program-specific progress note requirements:

Therapy: A progress note must be completed for each contact for outpatient therapy, including individual, group or family therapy. The progress notes must document therapeutic support interventions and activities that take place with/for an individual. The note will include a brief mental status exam, report on medication compliance (if applicable), and any suicidal/homicidal ideation.

Emergency Contacts, Community Support Services, Targeted Case Management, Recovery Support Services, Nursing/Medical services, Peer Support Services, Supported Employment: For each contact, an individual progress note must be completed. For Emergency Contacts, Community Support Services, Nursing/Medical Services, and Supported Employment, the note will include a brief mental status exam and report on medication compliance (if applicable).

Day Treatment: For children and youth in day treatment, daily documentation must be reflected based on program attendance and behaviors observed for a particular day. A weekly summary progress note must be completed to address activities/behaviors present during day treatment and progress towards the areas of need identified on his/her Individual Service Plan.

PSR/Senior PSR: For people receiving services in Psychosocial Rehabilitation and Elderly Psychosocial Rehabilitation, daily documentation must be reflected based on program attendance and behaviors observed for a particular day. A weekly summary progress note must be completed to address activities/behaviors present during program and progress towards the areas of need identified on his/her Individual Service Plan.

Community Living/Residential Services: Shift notes will be completed on each shift prior to staff members leaving the facility.

Structured Intervention/IOP/SUD Residential Services: For each individual, group, or family therapy, an individual progress note must be completed and should address progress towards the areas of need identified on his/her Individual Service Plan.

SUD Residential Services/CSU – Psychoeducational Groups: A psychoeducational weekly group note can be utilized to document non therapy/non process groups that were conducted to provide education. Topics to be address may include, but are not limited to, supportive counseling, recreational, social/interpersonal activities, self-help/personal growth, increasing self-esteem, wellness education, social skills, anger management, the recovery process, vocational/educational counseling, or related skills.

IDD Supervised Living, Home and Community Supports, IDD Supported Employment: IDD Service Notes are used to document activities that take place during the provision of services and must be detailed and specific to each person's Activity Support Plan.

Prevocational Services, Day Habilitation, Day Services–adult, Work Activity: IDD Weekly Service Notes are completed to document activities that take place during the provision of services and specific to each person's Activity Support Plan.

Note to File: A note to file should be made when needing to document clinically relevant information that is not tied to a specific billable/direct service (i.e., cancelled appointment, telephone contact, information related to a Serious Incident).

Mississippi Operational Standards addressed: Rule 16.7D-F, DMH Record Guide

Section: Clinical Issues
Policy:
Policy No: CI 04
Effective:
Revised/Approved:

Reserved for future use

Section:	Clinical Issues
Policy:	Individual Receiving Services Initiated Discharge prior to Completion of Treatment Goals
Policy No:	CI 05
Effective:	01/01/1995
Revised/Approved:	03/28/2017

POLICY: It is the policy of Community Counseling Services (CCS) to have appropriate staff members contact people who initiate the discontinuation of services prior to the completion of treatment goals and objectives.

PURPOSE: The purpose of this contact is to gather information concerning the person's/significant other's dissatisfaction and to attempt to resolve the problems, thereby attempting to support the person continuing in needed services.

PROCEDURE: If a person chooses to initiate discontinuation of services prior to the completion of treatment goals and objectives, the assigned therapist will attempt to contact the person to gather information about their desire to discontinue services. Documentation of the attempt to contact the person will be made in the medical record of the person receiving services. The therapist and/or designated staff will attempt to resolve any concerns the person and/or family may have to promote the continuation of necessary services. Ultimately it is up to the person or his/her parent/guardian (in the case of minors) if they want to continue service with CCS. If the individual decides they no longer want services, the case will be closed by completion of the provider discharge form.

Section: Clinical Issues
Policy: Pre-Evaluation Screening and Civil Commitment Services
Policy No.: CI 06
Effective: 01/01/1997
Revised/Approved: 03/27/2017

POLICY: It is the policy of Community Counseling Services (CCS) that Pre-Evaluation screenings of those persons being considered for commitment to a State Hospital shall be performed in a timely, efficient, and compassionate manner. Pre-Evaluation Screening and a Civil Commitment Examination are two separate events which include screening and examinations, inclusive of other services to determine the need for civil commitment and/or other mental health services, including outpatient or inpatient commitment. These services also include assessment and plans to link individuals with appropriate services and can only be provided by a DMH/C.

PURPOSE: To ensure that all people and their families receive high-quality services while engaged in the process of the consideration of civil commitment to a State Hospital. To conform to all laws of the State of Mississippi and to all appropriate regulations/standards of the Department of Mental Health (DMH)

PROCEDURE: Pre-Evaluation Screening and a Civil Commitment Examination are two separate events which include screening and examinations, inclusive of other services to determine the need for civil commitment and/or other mental health services, including outpatient or inpatient commitment. These services also include assessment and plans to link people with appropriate services and can only be provided by those Community Mental Health Centers who or certified by DMH as a DMH/C.

It is the responsibility of the Executive Director to ensure that CCS has implemented a written plan that describes how the program meets the requirements of the Mississippi civil commitment statutes. This plan must describe by county:

- The system for conducting Pre-Evaluation Screenings
- The system for conducting Civil Commitment Examinations
- The system for handling court appearances
- The services that are offered for the family and/or significant others
- The system for assuring that a person being screened and/or evaluated for civil commitment and his/her family/significant others have access to a staff member knowledgeable in the civil commitment process

Individuals qualified to conduct Pre-Evaluation Screenings: The Pre-Evaluation Screening must be conducted by a qualified staff member of CCS and be performed by:

- A certified licensed psychologist or physician or
- A person with a Master's degree in a mental health or related field who has received training and certification in Pre-Evaluation Screening by the DMH and provides documentation of at least six (6) months of experience working with individuals with SMI or SED or

- A registered nurse who has received training and certification in Pre-Evaluation Screening by the DMH and provides documentation of at least six (6) months of experience working with individuals with SMI or SED

The Human Resources Department will maintain documentation of those qualified to conduct pre-evaluation screenings in accordance with state statute.

Documentation: Pre-Evaluation Screenings must be documented on the specified forms as outlined in the DMH Record Guide. The Pre-Evaluation Screening must be performed in accordance with current Mississippi civil commitment statutes and provide the information required by the civil commitment law and/or the DMH.

Civil Commitment Examination: If the Civil Commitment Examination is conducted, the examination must be performed by two (2) licensed physicians, or one (1) licensed physician and either one (1) psychologist, nurse practitioner or physician assistant. The nurse practitioner or physician assistant conducting the examination shall be independent from, and not under the supervision of the physician conducting the examination.

Documentation: Be documented on required forms, and provide information required by law or the DMH. Documentation must include information in the person's record of the Commitment Examination results and the official disposition following the examination. Also included in the evaluation should be the person's social and environmental support systems. Include, when possible, the development of a treatment and follow-up plan for the person and the family and/or significant others.

Miss. Code Ann. § 41-21

All processes/procedures set forth in this document shall be conducted in a manner which strictly conforms to Mississippi law, specifically Mississippi Code of 1972, Title 41, Chapter 21. At all times, less restrictive treatment possibilities shall be considered in order to assess, plan for and link people with appropriate services.

Referral: Referrals for Pre-Evaluation screening come to CCS in one of two ways: 1) The person receiving services or his/her family member or 2) an interested person. If the person receiving services, family or interested person contacts CCS about the possibility of commitment to a State Hospital, the inquirer is informed that they may make an affidavit of the fact and shall file the affidavit with the clerk of the Chancery Court of the county in which the person alleged to be in need of treatment resides or in the county where the person is found. The Chancery Clerk, upon direction of the Chancellor of the Court shall:

- Issues a Writ to Take Custody directed to the Sheriff commanding him to take the respondent into custody
- Orders a Pre-Evaluation screening by an appropriately qualified CCS staff member
- Appoints and summons two licensed physicians or a licensed physician and a psychologist/nurse practitioner/physician assistant to examine the respondent, pursuant to a recommendation by the therapist conducting the pre-evaluation screening

The person is brought to CCS by order of the Chancery Court for the purpose of screening the person for preliminary recommendations concerning whether or not there is a need for commitment to a State Hospital

Process: The Sheriff's office takes the respondent into custody, makes arrangements for the evaluation and transports the respondent to the appropriate county office of CCS. If circumstances warrant, the evaluation may be conducted at a hospital, jail or other secure location where confidentiality can be maintained. Every effort will be made to accommodate the needs of the person in need of assessment, families and the courts in each county. A pre-evaluation screening will be conducted by a clinical staff member eligible to conduct the screening. The staff member shall complete the Pre-Evaluation Screening Form prepared by DMH or other forms or information required by civil commitment law or DMH utilizing:

- Information provided by the respondent's family/significant other
- An interview with the respondent
- A mental status examination of the respondent
- If the respondent is a service recipient of CCS, information from the medical record
- Information supplied by a CCS staff member who provides services to the respondent
- Other information supplied by the person's physician, attorney, etc.

The individual conducting the screening shall make a recommendation to the court as to whether or not the commitment process shall be continued. The original of the Pre-Evaluation Screening Form shall be sent by the sheriff's deputy accompanying the respondent to the court. For persons not receiving services from CCS, a copy shall be placed in the Pre-Evaluation Screening/Civil Commitment Exam file in the Medical Records office. If the respondent is a service recipient of CCS, a copy shall be placed in his/her medical record. A copy of the Pre-Evaluation Screening From (both non-CCS recipients or CCS service recipients) shall also be sent to the billing department for reimbursement.

Pre-Evaluation Screening Conducted/Commitment not Recommended: If the respondent is found not to meet the criteria for commitment to a State Hospital, the Chancery Clerk is so advised. If the Chancery Clerk follows the recommendation of the pre-evaluation screening, the respondent is released and the case is dismissed.

Pre-Evaluation Screening Conducted/Commitment Recommended: If the respondent is judged to need the commitment process continued, an appointment is made with the medical/psychological examiners. An interview is conducted with the respondent by the court-appointed examiners and is documented by the completion of the Civil Commitment Examination form or other such forms or information as required by law or DMH. Information will be placed in the medical record (for CCS recipients of service) regarding examination results and recommendation. For non-CCS recipients, the Civil Commitment Examination will be filed in the Pre-Evaluation Screening/Civil Commitment Exam file in the Medical Records office.

A report of findings is sent to the Chancery Clerk. The examiners shall recommend that the respondent be:

- Committed (inpatient or outpatient)
- Not committed

If the examiners recommend that the respondent be committed, the Chancery Clerk issues an order of a pending hearing. A hearing is then set and the first order of commitment is signed. CCS personnel performing pre-evaluation screenings shall comply with any court order to give testimony in a civil commitment proceeding.

Services to families/significant others: CCS personnel shall attempt to deliver whatever services are required by the families/significant others of persons involved in the civil commitment process. Such services include, but are not limited to:

- Education/consultation/information regarding the process of civil commitment by a staff member knowledgeable in the commitment process.
- Support services to aid the person in carrying out the process
- Emotional support to aid the person/family in coping with the necessity of committing a loved one to a State Hospital

Mississippi Operational Standards addressed: Rule 34.2

Section: Clinical Issues
Policy:
Policy No: CI 07
Effective:
Revised/Approved:

Reserved for future use

Section: Clinical Issues
Policy:
Policy No: CI 08
Effective:
Revised/Approved:

Reserved for future use

Section: Clinical Issues
Policy: Sex-Related Behaviors
Policy No: CI 09
Effective: 03/01/1994
Revised/Approved: 03/28/2017

POLICY: It is the policy of Community Counseling Services that kissing, hugging, hand-holding, "sexual talk", fondling, sexual intercourse and other forms of sexual behavior among people in services is expressly forbidden in public areas. Auto-erotic behaviors, such as masturbation, and sexual behaviors between consenting adults are allowed provided they are not in conflict with the treatment goals or physical health needs of the person and are practiced in private (residential units only).

PURPOSE: To ensure that each person deals with his/her sexuality and related behaviors in a manner which is appropriate to his/her age and the treatment environment.

PROCEDURE: All incidents of sex-related behaviors will be reported immediately, whether directly observed or reported. The staff member who is aware of the behavior must report immediately to:

SUD Residential facility: PACH Clinical Coordinator or his/her designee

Outpatient Program: The County Administrator/Supervisor

Community Living facilities: Respective County Administrator

Sex-related behaviors will be documented accordingly in the medical file of the person(s) involved.

If the behavior involves kissing, hugging, handholding or sexual talk, the staff will use redirection and education regarding program rules as needed to address behavior. The treatment team will develop individualized plans as needed for addressing these behaviors with specific individuals. If the behaviors include fondling, sexual intercourse or other behaviors of comparable physical intimacy, the attending staff will:

- Complete an incident report form
- Contact the appropriate supervisor as indicated above

The supervisor will then make a decision about the need to keep the involved individuals physically separated from one another until the treatment team can meet to evaluate the situation and plan appropriate intervention strategies which will include:

- Consultation with treatment team members
- Development of a plan to help ensure that such behavior will not re-occur
- If the person is a child or adolescent, informing the legal guardian of the incident and the planned intervention strategies

Discharge/Consequences for unacceptable sex-related behaviors: If a behavior support plan has been developed or there are specific program rules which define inappropriate

sexual behaviors, the person may be discharged or other appropriate consequence implemented for unacceptable sex-related behaviors. The safety of all individuals participating in programs offered through Community Counseling Services will be of primary concern when making decisions regarding continued services of the person engaging in unacceptable sex-related behaviors.

Section: Clinical Issues
Policy: Individual Service Plan Development & Review
Policy No.: CI 10
Effective: 01/01/1995
Revised/Approved: 7/27/2021

POLICY: It is the policy of Community Counseling Services (CCS) that individual service plans be formulated and utilized according to DMH Operational Standards and the DMH Record Guide. It is also the policy of CCS that when treatment of a person involves more than one service and more than one staff discipline, that all of the involved service providers participate in the service planning process and staffing of those plans. Each member of the interdisciplinary treatment team who shares responsibility for implementation of the plan must sign the plan. Supervisors may sign in lieu/on behalf of staff members he/she directly supervises.

PURPOSE: To ensure that Individual Service Plans are developed with input from an interdisciplinary team which includes ideas and expertise of all staff members who have contact with the person and his/her family. To develop a plan that utilizes approaches that are considered to be best practices or evidence-based by their respective areas of focus. To foster the development of objectives and strategies which are most effective in the treatment and care of the person. To ensure that the individual service plan is developed promptly and is utilized in a manner which aids in the delivery of meaningful services to people based on their personal recovery goals.

PROCEDURE: The individual plan is the overall plan that directs the treatment/support of the person receiving services and should guide the services/approaches utilized in providing care. The individual plan should be designed to increase or support independence and community participation. The Individual Plan may be referred to as the Treatment Plan, Plan of Services and Supports, Individual Service Plan, Wraparound Plan or Person-Centered Plan. The name of the plan is dependent upon the population being served and the process utilized to develop the plan. The plan must be based on the strengths, challenges, desired outcomes, and activities to support outcomes of the person receiving services and his/her family/legal representative (if applicable). Outcomes should be identified by the individual, family/legal representative (if applicable), and treatment/support team.

Outcomes: Expected outcomes include, but are not limited to, the following: a) the person will experience and report improvement in his/her quality of life, b) the person will become more involved in his/her plan of care, c) the person will utilize skills that lead to improved mental health, and d) the person will make progress in reaching individually identified recovery goals.

Planning approaches: An individualized treatment team is developed for each person receiving services that includes the person, service providers, and other providers of support (as appropriate) that may be identified and utilized by the person or team members. The individual plan should have a focus on recovery/resiliency, while supporting the need for services and diagnostic criteria. Strengths will be identified and the treatment team will build upon strengths to achieve positive outcomes. Proactive crisis planning will be incorporated as appropriate and at a minimum, the Crisis

Support Plan will be developed for the priority groups indicated in DMH Operational Standards and DMH Record Guide.

Adults with a serious mental illness and children/youth with serious emotional disturbance must be seen in person or by telemedicine and evaluated by a licensed physician, licensed psychologist, psychiatric/mental health nurse practitioner, physician assistant, licensed professional counselor (LPC) , licensed marriage and family therapist (LMFT), or licensed certified (clinical) social worker (LCSW) to certify that the services planned are medically/therapeutically necessary for the treatment of the person. These professionals must see the person face-to-face or by telemedicine annually (or more often if medically indicated) to certify the same information in the person's record. Certification and recertification must be documented as part of the individual plan.

Plan Development: The therapist, with input from the person and his/her family/parent/legal guardian, are involved in the development of the service plan. The plan must address, or be revised to address, the strengths and needs of the individual. In addition, information gathered from the initial assessment, the completion of a functional assessment, or other assessment instruments utilized will be incorporated into the plan of care. The person receiving services (and his/her parent/legal guardian if appropriate) must sign the individual service plan. A complete individual service plan is a plan which has been written, staffed, and authorized by an appropriate provider. It is the responsibility of the assigned therapist to present the individual plan to the interdisciplinary treatment team for staffing within the appropriate time period.

The individualized service plan must include, but is not limited to:

- Diagnoses and diagnosis codes based on the most current version of the DSM and applicable ICD codes identified
- Identified barriers and strengths of the person as reflected by intake/initial assessment and/or progress notes
- Long term and short term goals
- Areas of need
- Individualized, measurable objectives with associated interventions, services, and outcomes for completion
- Identification of recommended services and whether or not the person chooses to participate in Community Support Services
- Input from the person receiving services and/or parent/legal guardian and the staff member responsible which is indicated by the signature of each person
- Signature authorizing services (licensed physician, licensed psychologist, psychiatric mental health nurse practitioner, LCSW, LMFT, LPC)

Timelines for plan development for specific services are as follows:

- Outpatient Services: Within thirty (30) days of admission, updated as needed and reviewed/rewritten at least annually.
- Substance Use Primary Residential Treatment Services: Within seven (7) days of admission, updated as needed and reviewed/rewritten at least annually.
- Substance Use Transitional/Secondary Treatment Services: Within fifteen (15) days of admission, updated as needed and reviewed/rewritten at least annually.
- IOP Substance Use Services (Adult & Adolescent): Within thirty (30) days of

admission, updated as needed and reviewed/rewritten at least annually.

- Structured Intervention- Within thirty (30) days of admission, updated as needed and reviewed/rewritten at least annually.
- Community Living SMI: Within fifteen (15) days of admission, updated as needed and reviewed/rewritten at least annually.
- Crisis Response Services: Within seventy-two (72) hours of admission, updated as needed and reviewed/rewritten at least annually.

Updates: The service plan shall be updated as necessary to accurately reflect changes in current circumstances. Updates shall include, but are not limited to, revised therapeutic goals and progress/lack of progress towards objectives identified on the ISP. Additions/changes must be clearly identified, and must be signed by staff members and the person receiving services/guardian(s) as required by standards and reimbursement sources. Addenda to the original plan shall be indicated by selecting addendum on the Individual Service Plan. The treatment plan shall be rewritten no less than every twelve (12) months, based on the response to treatment of the person and his/her current level of functioning. The annual rewrite will be indicated by selecting re-write on the Individual Service Plan. A primary therapist shall be assigned to each new person receiving services. The team member, known as the "Manager/Counselor of Record", has primary responsibility for ensuring that the individual service plan remains current and responsive to the changing needs of the person throughout treatment and that annual re-writes are completed in accordance with established timelines.

Interdisciplinary treatment team meetings (staffings): Staffings are designed to foster collaboration with treatment team members to ensure that all areas are addressed on the Individual Service Plan to help the person achieve stated recovery goals. Team meetings aid in the consistent measurement of progress of the person receiving services, accountability for specific plans and clarity of follow-up responsibilities. Staffings must occur on a regularly scheduled basis with sufficient frequency and duration to complete necessary service planning and review (including the discussion of the progress of the person toward treatment goals) for all people receiving services. Treatment team members are expected to attend staffings as scheduled. Each time a person's plan of care is discussed, documentation must be maintained in the medical record either on the Individual Service Plan, the Periodic Staffing/Review of the ISP, or in the progress notes. Staffings should be conducted in a manner which results in the most effective use of time to achieve treatment team goals, including a) collaborating in decisions regarding the optimum strategies for treatment of the person receiving services, including the statement of specific goals and objectives, b) designating staff members responsible for the implementation of treatment for the person, and c) designating time frames for goal attainment, discharge, reevaluation and revision.

Determining medical/therapeutic necessity: Once the ISP is staffed, an approved provider (see Policy GS 01) will review the plan and sign authorizing services. When the approved ISP is signed by the physician, necessary prior approvals will be obtained and services will be delivered as approved.

Periodic Staffing/Review of the ISP: The Individual Service Plan will be reviewed and/or revised at least annually and as specified in DMH Operational Standards and DMH Record Guide. These timelines are established as follows:

- Outpatient Adult: Yearly
- Outpatient Children and Youth: Every six (6) months
- Day treatment services: Every thirty (30) days
- Substance Use Primary Residential Services: Every fifteen (15) days
- Substance Use Transitional/Secondary Residential Services: Every thirty (30) days
- IOP Substance Use Services (Adult & Adolescent): Every thirty (30) days
- Structured Intervention/Recovery Support/General SUD Outpatient – Every Ninety (90) days

The Periodic Staffing/Review of ISP is utilized in the review of the individual service plan of the person receiving services, whether it is a scheduled periodic review or a review due to a change in the condition of the person. Reviews shall include a review of therapeutic goals, with an emphasis placed on progress or lack of progress made towards objectives identified on the ISP. It is the responsibility of the assigned therapist to ensure that the individual service plan for the person is reviewed in a timely fashion and that all service providers working with the person participates in that review. Each member of the interdisciplinary treatment team who has responsibility for implementing the plan must sign the Periodic Staffing/Review of ISP. (As previously noted, appropriate supervisory personnel may sign for treatment team members.) As much as is possible, the person and/or his /her family/legal guardian should be involved in the review of the service plan. The person receiving services (and his/her parent/guardian if appropriate) must sign the service plan update if there is a change to any area of the individual service plan. If it remains the same, it is not necessary for the person/parent/guardian to sign the review, but there should be documentation in the progress notes section of discussing with the person and/or parent/legal guardian regarding progress review. If there is a change in the diagnosis or a change in the services which are being provided, an approved provider must sign authorizing the updated/revised Individual Service Plan.

Annual Update/Re-write of ISP: The annual update must be conducted during the twelfth 12th month after the initial intake or the readmission date. All providers will review the individual service plan on a cycle consistent with the original intake date or the date of readmission. All annual updates of the ISP, must be signed by an approved provider authorizing care.

Treatment plan implementation: Supervisors shall ensure that services/program activities are designed to address objectives and recovery goals outlined on the individual service plan. At a minimum, individual plan objectives must reflect individual strengths, needs, interventions, and criteria/outcome for completion of individualized objectives. Programs provide each person with activities and experiences to develop the skills they need to function as independently as possible and reach his/her recovery goals. Services provided as outlined on the individual plan will be based on the needs of the person, in addition to, prior authorization approval for specified services.

Mississippi Operational Standards addressed: Rule 17.1, 17.2A, B

Section: Clinical Issues
Policy: Plan of Services and Supports for Individuals with IDD
Policy No: CI 11
Effective: 3/28/2017
Revised/Approved: 7/27/2021

POLICY: It is the policy of Community Counseling Services to complete the Plan of Services and Supports for people with intellectual/developmental disabilities who are not enrolled in ID/DD waiver of IDD Community Support Program in compliance with DMH Operational Standards and the DMH Record Guide. Each person has one Plan of Services and Supports (PSS).

PURPOSE: The purpose of the PSS is to document a person's vision of their desired life. It includes a description of the person's strengths, what is important to and for them, and supports necessary to live their best life.

PROCEDURE: The PSS is developed by the person with the involvement of others identified by the person, such as family, friends, and service providers. For CCS, the PSS is only developed by a CCS staff member or program for those people who are non-Waiver/IDD Community Support Program participants. Otherwise, the PSS is developed by the ID/DD Waiver Support Coordinator (SC), Transition Coordinator, or IDD Community Support Program Targeted Case Manager (TCM), and provided to the service provider. The planning team uses the PSS as a guide to develop needed paid supports and services, as well as, natural and unpaid supports from the community. It is the fundamental document used to assist the person in achieving their desired outcomes and thus their best life.

The PSS is divided into the following six parts and should be completed using the instructions outlined in the DMH Record Guide:

I. Essential Information
II. Personal Profile
III. Person Centeredness
IV. Signatures
V. Shared Planning
VI. Activity Support Plans

The person receiving services will lead the person centered planning process where possible. The person's representative/legal guardian should have a participatory role, as needed and as defined by the person. The meeting: (a) Includes people chosen by the person. (b) Provides necessary information and support to ensure the person directs the process to the maximum extent possible, and is enabled to make informed choices and decisions. (c) Is timely and occurs at times and places convenient to the person. (d) Reflects the cultural considerations of the person. (e) Includes strategies for resolving conflict or disagreement within the process including clear conflict-of-interest guidelines for all planning participants. (f) Offers informed choices to the person regarding the services and supports they receive and from whom. (g) Includes a method for the person to request updates to the plan as needed. (h) Records the alternative home and community based settings that were considered by the person.

Information Gathering: The PSS should paint a picture of the person's life. The person is the expert on his/her life and should contribute as much information as possible. Other team members should consist of the supports in the person's life that are closest and know him/her the best. All providers that work closely with the person are required to contribute to the PSS. The PSS should help the team understand the person, what the person wants and needs, and how best to support him/her to live the life he/she desires. With the person's permission, information is also obtained from others with whom the person interacts. These supports may not be able to attend the PSS meeting but can contribute information prior to the meeting. This information is gathered over the phone and documented in planning notes, along with the date the conversation took place, with information gathered shared at the planning meeting. Person Centered Thinking Skills will be used during the planning meeting to gather information. The Person Centered Thinking skills provide a structure for gathering information during a conversation rather than simply having a question/answer session. Staff should remember to ask "why," especially when people give yes/no answers. "Why" provides an important avenue of exploring topics further.

For non-Waiver/IDD Community Support Program participants, the PSS must be completed annually or within 30 days of admission to service, with the Activity Support Plan being developed within 30 days of when the PSS was developed. The PSS must include/address the following:

- Reflect the services and supports that are important to the person to meet needs identified through an assessment of functional need as well as what is important for him/her with regard to preferences for the delivery of such services and supports.
- Reflect that the setting in which the person resides is chosen by the individual. The setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as an individual not receiving IDD services.
- Reflect the person's strengths and preferences.
- Reflect clinical and support needs as identified through the functional assessment.
- Include individually identified outcomes for services.
- Reflect the services and supports (paid and unpaid) that will assist the person to achieve identified outcomes and the providers of those services and supports, including natural supports.
- Reflect risk factors and measures in place to minimize them, including individual back-up plans and strategies when needed.
- Be understandable to the person receiving services and supports, and the people important in supporting him/her. At a minimum, the PSS must be written in plain language and in a manner that is accessible to people with disabilities and persons who have limited English language proficiency.
- Identify the person and/or entity responsible for monitoring the PSS.
- Be finalized and agreed to, with the informed consent of the person in writing, and be signed by all people and providers responsible for its implementation.
- Be distributed to the person and others involved in implementing the PSS.

- Must prevent the provision of unnecessary or inappropriate services and supports. Must document that any modifications made to a person's ability to access the community or make choices about his/her daily life:
    - Identify a specific and individualized assessed need.
    - Have documentation of the positive behavior interventions and supports used prior to any modification of the person centeredness of the PSS.
    - Have documentation that less intrusive methods have been tried and did not work.
    - Include a clear description of the condition that is directly proportionate to the specific assessed need.
    - Include regular collection and review of data to measure the ongoing effectives of the modification.
    - Include established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.
    - Include the informed consent of the individual.
    - Include an assurance that interventions and supports will cause no harm to the individual.
- Reviewed and revised upon reassessment of the functional need, at least annually, when the individual circumstances or needs change significantly, or at the request of the person.

Mississippi Operational Standards addressed: Rule 17.2C

Section: Clinical Issues
Policy:
Policy No: CI 12
Effective:
Revised/Approved:

Reserved for future use

Section: Clinical Issues
Policy: Inpatient Referral
Policy No.: CI 13
Effective: 01/01/1997
Revised/Approved: 7/27/2021

POLICY: It is the policy of Community Counseling Services (CCS) to provide access to inpatient services as near to the locale of the person receiving services when the services of inpatient care are appropriate.

PURPOSE: To facilitate aiding the person in remaining in his/her own community/area so that he/she may utilize family and peer support while receiving inpatient care.

PROCEDURE: It is the responsibility of the Executive Director to ensure that access to inpatient services in the catchment area is available to all persons needing the service and to ensure that there are written policies and procedures for referral to inpatient services in the community, should a person require such services and for adults, when the use of CCS' Crisis Stabilization Unit is not available or appropriate.

Agreements: CCS maintains a current written agreement with Baptist Memorial Hospital, Golden Triangle Behavioral Health Unit to provide/make available inpatient services to adults receiving services from CCS who require and are appropriate for hospitalization and with Diamond Grove Center to provide inpatient services (both acute and residential care) for children/youth for which psychiatric hospitalization is required. The agreement will address at a minimum:

- Identification of CCS' responsibility for the person's care while the person is in inpatient status
- A description of services that the hospital will make available to people who are referred
- How hospital referral, and admission and discharge processes are coordinated with crisis services, Pre-Evaluation Screening Civil Commitment Examination services, and aftercare services.

Responsibilities while in inpatient care: Adults in the care of Baptist Behavioral Health and children/youth in the care of Diamond Grove are monitored by CCS personnel when able. However, all responsibility for the care of the person belongs to Baptist Behavioral Health and Diamond Grove during the length of hospital care.

Service availability: People receiving services from CCS who are hospitalized have access to all inpatient treatment modalities in the two institutions listed above.

Referral: It is the responsibility of each County Administrator/Supervisor to ensure that referral to an inpatient facility is coordinated with the treatment team to respond to emergency and/or pre-evaluation screening and civil commitment services (if warranted). If the person receives services from CSS, the treating staff psychiatrist, if available, shall be consulted to assess whether inpatient referral is appropriate and to assist with the referral process. When available, a doctor to doctor referral is preferred.

Before referring a child/youth to a Psychiatric Residential Treatment Facility (PRTF),

CCS must first attempt to have the local MAP Team review the situation to ensure all available resources and service options have been utilized. This does not include those children/youth who are in immediate need of acute hospitalization due to suicidal or homicidal ideations.

People being released from a State Facility (EMSH): CCS has a designated staff member to serve as a liaison with East Mississippi State Hospital. This person assists with the arrangements for service delivery upon return to the community. It is expected that procedures outlined by the Discharge Transition Workgroup are utilized and followed. Ideally, intakes will be conducted virtually prior to discharge to connect the person being discharged with CCS, as well as, to promote a seamless transition to outpatient services. When possible and appropriate consents are present, family members will be encouraged to participate in this process. Necessary contact information is provided to the Social Services Department at EMSH.

The following priority groups of people with serious mental illness, children/youth with serious emotional disturbance and people with an intellectual/developmental disability must receive an initial assessment within fourteen (14) days of the date that services are sought and/or the date the referral is made

a) People discharged from an inpatient psychiatric facility
b) People discharged from an institution
c) People discharged or transferred from Crisis Residential Services
d) People referred from Crisis Response Services.

- If indicated by the initial assessment, the priority groups listed above shall receive Psychiatric/Physician/PMHNP services within fourteen (14) days of the date of his/her initial assessment unless the individual states in writing, that he/she does not want to receive the service.

- CSS services will be offered to the priority groups listed above within fourteen (14) days of the Initial Assessment unless the individual states in writing that he/she does not want to receive the service.

Any individual being released from inpatient care in a facility other than EMSH will be given appointments as specified above provided CCS is made aware of his/her discharge.

Mississippi Operational Standards addressed: Rule 16.2B, 16.8C, 20.1D, 21.1B, 34.1

Section: Clinical Issues
Policy: Discharge Due to Behavioral Issues
Policy No.: CI 14
Effective: 03/22/2011
Revised/Approved: 07/27/2021

POLICY: It is the policy of Community Counseling Services (CCS) that people who continue to persist in behaviors that pose a risk of harm to other people receiving services, despite all efforts of staff members to aid the person in overcoming the behavior, may be discharged because of the behavioral issues.

PURPOSE: To eliminate danger to the person, to other people receiving services, and to staff members from uncontrolled challenging behaviors.

PROCEDURE: Serious inappropriate behaviors which regularly disrupt treatment programs or pose a risk for harm (whether physical or emotional) must not be allowed to continue. Inappropriate disruptive or threatening behaviors must be addressed by program staff members upon their first appearance. The CCS staff member observing the behavior (or his/her supervisor if appropriate) shall immediately take the individual to a quiet, private place where the behavior can be discussed. CPI skills shall be utilized in bringing the situation under control. The staff member shall address the following:

- Reason(s) the behavior is inappropriate
- Alternative appropriate behavior (with information regarding how to implement the appropriate behavior)
- Consequences of repetition of the behavior

The staff member/supervisor addressing the behavior with the person shall document the behavior and the staff member's/ supervisor's discussion with the person for inclusion in the medical record. If the staff member/supervisor who addressed the behavior with the person is not the person's therapist, a copy of the documentation shall be given to the therapist, who shall also address the behavior with the person and shall document the discussion and its results for inclusion in the individual's record.

Should the behavior continue, the person shall again be taken to a quiet, private place where the staff member (or his/her supervisor if appropriate) shall again discuss with the person, utilizing all necessary CPI skills, the issues addressed above. The staff member/supervisor will also:

- Document the behavior and discussion for the individual's record
- Deliver a copy of the documentation to the person's therapist if applicable
- Impose or cause to be imposed the consequences for the behavior previously established

Should the behavior continue to occur, the person's therapist, other service providers, the person and/or his/her family member/legal guardian shall meet together to discuss the behavior to determine whether the persons behavior and/or actions are putting other people at risk for harm (whether physical or emotional). Unless the behavioral issues put the person or others receiving services at significant risk, prior to discharging someone from a service of any type due to challenging behavioral issues, the presence,

documentation, and implementation of a Behavior Management Plan must be confirmed. All efforts to keep the person enrolled in programs and/or any CCS service must be documented in the record.

If the determination is that the behavior/actions are putting other people at risk for harm (whether physical or emotional), the development of the Behavior Management Plan is not required. The person's primary service provider shall consult with his/her immediate supervisor, as well as, the Chief Operations Officer (COO) regarding actions taken and the determination that people are at risk for harm. If the COO concurs, the service provider shall discharge the person from services with approval of the Executive Director and documentation regarding the reason for the discharge to be included in the person's record. Should the COO not concur with the determination, the treatment team will follow the COO's recommendations for further action to manage the person's behavior(s). All actions taken by any service provider regarding any part of this policy shall be documented in the medical record.

Mississippi Operational Standards addressed: Rule 16.5H