SCIOTO PAINT VALLEY MENTAL HEALTH CENTER

AGENCY SERVICE PLAN

PURPOSE, PHILOSOPHY, GOALS AND OBJECTIVES

FY 2016

AGENCY SERVICE PLAN

TABLE OF CONTENTS

AGENCY SERVICE PLAN

FY 2016

PURPOSE, PHILOSOPHY, GOALS AND OBJECTIVES

INTRODUCTION

The Scioto Paint Valley Mental Health Center is the agency that has been designated, in the Paint Valley Mental Health, Alcohol and Drug Addiction Board Community Plan, to meet the mental health needs of the five county service districts. The counties that comprise the Board's service district include Ross, Pickaway, Pike, Fayette and Highland. The Center's purpose, goals, objectives and service philosophy have grown out of needs assessment activities that have been conducted by the Board and Center over the past 30 years. Needs assessments are conducted on an ongoing basis so that Center goals, objectives, and services can be amended to reflect changes in community needs that occur over time. The Paint Valley ADAMH Board, in FY'02, updated the Needs Assessment. The needs of SMD adults and SED children were assessed by outside consultants. This resulted in modifications to the service delivery system. The Center closed the Children's Residential Center and initiated an intensive community-based program for children. An intensive case management program was started for SMD adults in Highland County and the Center obtained certification to provide Vocational Service to the severely mentally disabled adult population.

The mission or purpose of the Center is defined by the Center's Board of Trustees and reflects community mental health needs that have been identified in the Mental Health Board Community Plan. The mission or purpose of the Center is to provide leadership and services in a community-wide effort to foster positive, optimal mental health and to assist the community to find ways to prevent, reduce, and minimize the residual effects of mental health problems.

The Center's service philosophy is an outgrowth of its mission and delineates the beliefs and values of the Board of Trustees as pertains to the provision of services. This service philosophy is the underpinning for all services that are provided by the Center. The service philosophy is as follows:

We believe that the provision of services should be available and accessible to everyone within our catchment area without regard to race, color, religion, sex, age, national origin, or handicap.

We believe that appropriate efforts to resolve mental health issues and problems in the community regarding planning and delivery of services is best achieved by a partnership between the community and the mental health center.

We believe that we are accountable for material and human resources expended by the community mental health center. This is to assure the existence of mental health services of a high quality and of the strictest confidentiality.

To actualize its mission the Center Board of Trustees has established goals and objectives that serve as measures which assist in the process of defining services that the Center has chosen to provide. These include:

1. To provide community support services including treatment, community psychiatric support treatment and residential care for community residents who are severely mentally disabled.

2. To provide for the deterrence of severe effects of stress and life crisis for children and adults, individuals and families who request assistance to increase adaptive behavior and restore positive functioning.

3. To provide continuously accessible emergency intervention for persons in crisis.

4. To provide treatment for persons identified as substance abusers and to promote community education and prevention of substance abuse. To provide community consultation, education and prevention, to promote positive community mental health.

5. To expand services to employed persons through the provision and promotion of Employee Assistance Programs.

6. To attempt to expand community treatment and community care alternatives for children and adolescents.

7. To strive to acquire adequate financial resources to support the provision of quality mental health services.

8. To maintain the Center's compliance with certification, auditing, licensure and funding standards and regulations.

The Center provides services to clients on the basis of least restrictive alternative. The term least restrictive reflects the value that clients should have as much freedom as possible to live in the community. Clients should not receive excessive services but only types and amounts of services that are necessary to ameliorate their mental health condition.

Selection of services that the Center will provide is further defined by target groups that the Board of Trustees has established in conjunction with assessments of community needs. These target groups are defined as;

(a) Community residents who are severely mentally disabled, at risk of suicide, or in danger to themselves or others due to mental illness.

(b) Community residents who are experiencing a life crisis, substance use problems, abuse,

mental or emotional disturbances which handicaps their functioning in the community.

(c) Community service providers and employers, the forensic system, victims of disease related stress (HIV, Alzheimer's, etc.), and community residents with special needs.

HOURS OF OPERATION

Services listed above are provided at Center locations (satellite clinics and residential centers) at levels that are appropriate to the needs of persons served. Residential centers are operational 24-hours per day. Satellite clinics are operational between 8:00 a.m. and 5:00 p.m., Monday through Friday. In addition, each satellite clinic is formally open one evening per week. All Center services are accessible during these time periods. Other evening or week-end appointments for services are arranged based on client and/or community need. The Center's Hotline, 2-1-1 Information & Referral, Pre-Hospitalization Screening and Crisis Intervention Service are operational 24-hours per day, seven days per week.

AFFILIATIONS AND AMENDMENTS

The Scioto Paint Valley Mental Health Center independently provides all services for which it is certified.

ADMISSION AND EXCLUSION CRITERIA

Eligibility Criteria: All persons who live in the Center's service area are eligible for admission to any of the services that are provided by the Center. Inclusion in a service is based on the client's needs, desires and the Center's clinical judgment. Clients that have been discharged may be readmitted for an assessment. If a client was unsuccessfully treated the service mix and intensity will be assessed in an effort to assist the client with achieving a more successful treatment episode. Persons who reside within the Center's service area are eligible for services without regard to ability to pay to the extent that resources permit.

Service applicants who do not have a payer source will be diverted to psycho-education groups unless there is the presence of a clinical condition that warrants more traditional care. Persons who seek services and live outside the Center's 5 county service area are not eligible for subsidy from the Paint Valley ADAMH Board and are responsible for the full cost of treatment. The Center accepts Medicaid as a means of payment for persons who live outside of the center's service area.

INELIGIBILITY CRITERIA

Persons who do not meet the criteria above are not eligible to receive Center services. Clients, who fail to pay for their share of services on 2 consecutive occasions, will not be scheduled for further services until they pay their outstanding bill or unless there is a compelling clinical reason that is approved by a Center clinical manager. Clients who fail to appear for appointments on 2 consecutive occasions, and do not contact the Center to cancel their appointments, will not be scheduled for another appointment without the consent of their clinician.

ADMISSION CRITERIA AND DISCHARGE CRITERIA:

Admission Procedure: An admission form shall be completed for each person requesting ongoing services from the Center. Both clerical and clinical staff shall assist in the completion of the admission form. The demographic section, Application for Services and Consent to Treatment, and Fee for Services Agreement, must be completed prior to the delivery of services. Parental or guardian consent to treatment must be obtained for individuals under the age of 18 who are requesting services.

Center staff will provide the client with a copy of the Client Rights at the time the Consent to Treatment is obtained. Center staff shall make every effort to assure that the client understands the following:

1. The client's right to refuse any and all treatment services and their right to terminate from any or all treatment services if they choose to do so.

2. The risks and benefits of the recommended treatment services, of potential alternative treatment services and of refusing all treatment services.

3. The potential risks and consequences associated with a client decision to refuse or withdraw consent for any or all treatment services.

If the client Consent for Treatment is refused or withdrawn, Center staff shall make every effort to collaboratively develop alternative approaches with the client.

The following sections of the Admission Form may be completed as a part of or immediately following the Assessment: Initial DSM-IV Code, Referral Source, Client Ethic/Racial Category, Marital Status, Education Level, Primary Provider, Case Manager, Living Arrangements, Special Population Group, Primary Program and the sections required for substance abuse clients.

All family members who are to participate in services for a client should be admitted on the same admission form. Each form should be completely filled out and kept in the file of the identified client. Since each family member is a client of the Center under this system, each family member should receive a client number. The outside cover of the client file should indicate the series of client numbers within the file. The identified client should have the first number (12345-1) in the series and a diagnosis if the family is to be seen as a unit.

The Assessment in a family case should be written from a familial prospective. The clinician should indicate names of family positions (son, daughter, mother, identified client, etc.) each family member who has an admission form. Sections of the Diagnostic Assessment should include statements about the identified client and other family members. Summary statements may be used where appropriate as well as significant family information in that section.

Other documentation such as the ISP and Progress Notes should likewise reflect the relationship between the presenting problem and each family member.

When seeing an individual family member, other than the identified client, for a treatment session that is related to the family ISP, the session may be billed and documented under the identified client's name. This should be reflected on the SAL and documented in the progress note by placing the identified client's name under the client name. Under session activities the clinician should indicate the person seen and applicability of the intervention to the family problem(s).

If a family member, other than the identified client, needs to be seen individually on an ongoing basis independently of the services identified in the family ISP, a separate individual client record (ICR) containing a new admission form, diagnostic assessment, consent for treatment and other required documentation should be created and a non-dash case number assigned. These cases should be terminated independently from the family termination. If there is a need to open a separate ICR on more than one child in a family, the parent(s) may be opened as dashes on each of their children cases.

The fee for the initial visit should be billed to the prospective client identified at the first visit. Exceptions may be made when the initial contact is with Emergency Services or in an emergency situation when the initial contact is an outreach. However, the initial fee should be charged to these persons upon the second scheduled visit with Center staff. At this time, the person(s) should be admitted to the Center and a clinical record may be opened according to documentation procedures. Any contact with family members other than the identified client should be billed according to the fee set for the identified client.

Persons utilizing C&E services need not be admitted to the Center. However, a permission form must be obtained from the parent or legal guardian of minors when the minor is going to participate in a C&E service which is more than one session in length, e.g., groups in schools, Head Start, etc.

Persons utilizing Behavioral Health Counseling and Psychotherapy (Outpatient Counseling Services) in addition to the above eligibility criteria, require that prospective clients represent at least one of the Center's target groups as is outlined in #01-04 of the Scioto Paint Valley Mental Health Center Policy and Procedures Manual. In addition, the presenting problem must be linked to a mental or emotional disorder per the DSM IV. Length of stay is determined by the client having treatment issues that continue to meet Medical Necessity criteria.

Prospective clients may self-refer, or be referred for Outpatient Service by family, friends, significant others, courts, law enforcement officers, community agencies, attorneys, employee assistance programs, physicians, hospitals, or clergy. Regardless of the source of referral, the need for Outpatient Service must be established by a Scioto Paint Valley Mental Health Center clinician who is qualified to provide this service. The need and referral for Outpatient Service is reflected in the client's Individualized Service Plan.

Discharge Criteria: It is the practice of Scioto Paint Valley Mental Health Center to provide transition services, with the active participation of the client whenever possible, that may include but are not limited to: planned or unplanned termination of services, movement to a more appropriate level of service or provider, and/or referral for services not available at the Center in

accordance with applicable laws, standards and regulations. This procedure is developed to terminate a client from a service other than psychiatric services (see 05-04-05 Psychiatric Services-Service Termination p. 3) and to complete a termination summary.

There are four types of terminations: planned, unplanned/against the advice of the program, involuntary, and administrative.

1. The Termination Summary form is used for planned, unplanned/against the advice of the program, and involuntary types of discharges and includes the following information:
    a. Progress in treatment, outcomes, strengths, needs, abilities, and preferences.
    b. Need for support systems or other types of services.
    c. Information on medications, if applicable.
    d. Referral source information.
    e. Mental Health education on relapse prevention and access to crisis services.
    f. *For AOD clients only*-Completion of discharge BH mod and Level of Care forms.
2. Discharge planning begins at the time of assessment and the development of the ISP. Whenever possible, the client and/or parent or guardian shall participate in the development of the discharge plan.
3. Clinicians will evaluate their caseloads, on an on-going basis, to determine clients that have had no service for the past 90 days. (*Note: AOD clients must have discharge summaries completed within 30 days of last contact.)* Based on this list, the clinician will:
    a. Follow Procedure 05-01-08 (for mental health services only) and Procedure 07-01-01 (for AOD services only) by attempting to contact the client by letter indicating that unless the client responds within the indicated time frame, the case will be closed.
    b. If the clinician is unable to contact the client according to 05-01-08 and 07-01-01, the clinician completes the Termination Summary and other required AOD forms.
    c. If the client is being closed on the AOD side of the Center's services but is remaining open on the MH side, the clinician will complete discharge BH mod and Level of Care forms only. Clerical support will then close the case on the SA side but leave the case open on the MH side.
4. Involuntary Termination of services may occur for violence or threat of violence, including stalking; non-compliance with treatment; and/or illegal activities (e.g. altering prescription(s), etc.).
    a. A clinician who needs to pursue an involuntary termination must consult with his/her clinical supervisor and/or the appropriate Associate Director to discuss appropriate alternatives and the impact on other services the client may be receiving form the agency.
    b. The client will be informed of the decision, given a list of other providers/resources, and informed of their right to file a grievance. The Center will continue to provide crisis/emergency services as needed.
    c. The process of involuntary termination will be documented in the client's ICR using the Termination Summary.
    d. The appropriate Associate Director is responsible for following up with the client within 72 hours of discharge and ensuring linkage to appropriate care has occurred within 72 hours post discharge.

5. Administrative Discharges are completed using the Termination Summary under the following circumstances:
    a. The Clinic and/or Program Director will complete administrative discharges when the clinician is no longer with the agency and the client has not been referred to another provider.
    b. Clerical Supervisors will complete administrative discharged for those clients who only received a crisis service
6. Documentation-Clinicians are responsible for ensuring that all forms related to terminations are completed within the appropriate time frame and maintained in the client's ICR. Clinicians are responsible for mailing a copy of the Termination Summary to the client with a termination letter indicating how the client is to follow-up if the need for services arises and if indicated, any community resources. This should include the referral resources information, contact name, telephone number, and hours and days of operation. Note, if the client has exercised the right to restrict the uses and disclosures per HIPAA Procedure 12-02-04, the mailing of the Termination Summary and Letter will not occur.

MENTAL HEALTH SERVICES

PURPOSE, PHILOSOPHY, GOALS AND OBJECTIVES

ASSESSMENT/REFERRAL

Assessment is an intensive clinical evaluation that is conducted with all identified clients of the Center. The purpose of assessment is to ascertain the client's psychological state, purpose of involvement, strengths and limitations, social/occupational/familial levels of functioning, treatment needs, physical health needs and cultural characteristics that may be significant. It is through the process of Mental Health Assessment that a diagnosis is made and services to be provided are determined. Referrals are made for internal and external services. Mental Health Assessment is provided at all satellite locations and the Adult Residential Center. Providers of this service are individuals who meet criteria stated in the Department of Mental Health Certification Standards.

BEHAVIORAL HEALTH COUNSELING & THERAPY (OUTPATIENT SERVICE)

Behavioral Health Counseling & Therapy (formerly Counseling and Psychotherapy) involves face-to-face interventions with individuals, couples, families and groups. Children and adolescents are included and may be seen individually or in groups. Parents, guardians or significant others may be seen together with children (and adolescents) or independently as is specified in the Individualized Service Plan.

Behavioral Health Counseling & Therapy is provided via a process of interaction. Clients with any emotional disturbance, mental illness or substance abuse (alcohol and drug) problem may be eligible. This service may also be provided to persons experiencing impaired functioning due to problems of daily living, trauma, or interpersonal conflict. The type and modality of intervention is determined by the presenting problem and client needs as are expressed in the Individualized

Service Plan. Behavioral health Counseling & Therapy may be provided on a short term basis to enhance communication in a family situation, resolve marital discord, restore an individual's emotional stability following a traumatic event, or to augment a parent's ability to resolve a child's behavior problem. Counseling of a longer duration is usually provided to persons with chronic and severe psychiatric disabilities. Providers include persons from multiple disciplines (psychology, social work, counseling or other disciplines) who are qualified under criteria that have been established in the Department of Mental Health Certification Standards.

Targeted Client Population for Outpatient Treatment Program: Clients who are identified as having a severe mental disability (SMD) or serious emotional disturbance (SED); clients receiving partial hospitalization, residential treatment and/or pharmacological services; and clients identified as clinically appropriate by for outpatient treatment as recommended in their ISP conducted by a properly licensed staff member.

Service Ineligibility: Persons who do not reside within the Agency's service area, individuals who do not meet criteria described above (Target Client Population for Outpatient Treatment Program) and/or those unwilling or unable to pay for services in/when existing resources cannot support ongoing indigent care. It should be noted that individuals that do not reside within the Agency service area can access services if they are covered by Medicaid or have a Managed Care Provider that the Agency contracts with to provide services.

Outpatient Treatment Program Providers and Training: Each Agency service site shall have an outpatient treatment program with staff designated as outpatient treatment program providers who are qualified by the state to provide such services as outpatient treatment.

All clients receiving outpatient treatment services shall be assigned a primary outpatient treatment program provider. Responsibilities for the primary outpatient treatment program provider include but may not be limited to the following: building and maintaining a therapeutic relationship with the client; providing or ensuing the provision of all necessary outpatient treatment program services, knowledge of client history, assessments of support system, strengths and needs; establishing service goals and reviewing progress toward goal achievement with the client; and assuring required information and documentation is maintained in the Individual Client Record (ICR). Consistent with the Agency's team approach to Outpatient Treatment Program, the primary outpatient treatment provider may designate the provision of outpatient treatment program activities to other qualified center employees. This designation as well as the name of the other provider(s) should be indicated on the ISP.

Outpatient Treatment Program Providers shall continue to receive ongoing clinical supervision from their supervisor. Additionally, outpatient treatment program providers shall maintain license requirements by participating in internal and external trainings to keep state license current. This supervision shall be determined by the supervisor along with the supervisee and will be consistent with the employee's qualifications, experience and other clinically relevant issues such as client need, risk management and quality assurance.

Documentation of Outpatient Treatment Program Services: Staff members that are authorized by the state and their particular license to provide outpatient treatment services will be authorized to document these services with the appropriate agency activity codes. Staff members

that are not licensed outpatient treatment providers will not be authorized to provide outpatient treatment services to clients or document any progress notes with outpatient treatment activity codes. Provision of all outpatient treatment program services must be documented on the day of service and submitted with the provider service log.

PSYCHIATRIC SERVICES

Pharmacologic Management (formerly Medication/Somatic Service) involves medical interventions including prescription or supervision of medication and medical evaluations to address the behavioral health needs of persons served. This service is applicable to the Severely Mentally Disabled population (adults, children and adolescents) and other clients as may be identified by staff psychiatrists or clinicians. Pharmacologic Management is provided to clients at all locations associated with Scioto Paint Valley Mental Health Center. The service goal is to assess and evaluate client needs for psychiatric and pharmacological intervention toward the end of stabilizing, reducing or eliminating psychiatric symptoms. Pharmacologic Management targets behavioral health issues and is not designed to provide physical care. In addition to assessment and evaluation, procedures include prescription and supervision of medications. Services are provided by board eligible or certified psychiatrists, registered nurses and licensed practical nurses.

Service Access: Clients requiring psychiatric services will be triaged to assure prompt accessibility for clients with the highest need. Priority shall be given to clients who are determined to be a danger to self or others, in immediate need of psychiatric hospitalization, at imminent risk for psychiatric hospitalization, severely mentally disabled (SMD) or seriously emotionally disturbed (SED).

To be eligible to receive psychiatric services funded by the Paint Valley ADAMH Board, the client must be psychotic or have a diagnosis of Bipolar or Schizophrenia, meet income eligibility criteria, and there must be Paint Valley ADAMH Board funds available. Clients who do not meet this criterion will be expected to pay full fee. Full fee is expected to be paid prior to the service being rendered.

New clients being added to the service should be adults who are psychotic, bipolar, schizophrenia or have major depression with psychotic features and/or children who are psychotic, bipolar, schizophrenic or depressed.

Every effort should be made to schedule individuals being discharged from a State Hospital or the Floyd Simantel Clinic within 2 weeks of discharge. Individuals being discharged from private hospitals should be scheduled as soon as possible but may need to wait as long as 3 or 4 weeks.

Referrals to the psychiatrist from primary care physicians (PCP) may be scheduled if the referral meets the scheduling criteria. Questions from the primary care provider (PCP) should be brought to the attention of a psychiatrist or nurse practitioner. The psychiatrist or nurse practitioner will make every effort to discuss the problem/concern directly with the PCP and make treatment suggestions. In some cases the psychiatrist or nurse practitioner may decide to

see the referral for a one-time evaluation. Every effort will be made to schedule clients returning for psychiatric services with the psychiatrist who followed them previously in a follow-up time slot.

Service Eligibility: All persons who live in the Center's service area meeting the criteria described above (Service Access) are eligible for psychiatric services. Persons who reside within the Center's service area are eligible for services without regard to ability to pay to the extent that resources permit and meet subsidy criteria. Persons who seek services and live outside the Center's 5 county service area are not eligible for subsidy from the Paint Valley ADAMH Board and are responsible for the full cost of treatment. The Center accepts insurance for which we have a contractual obligation, including Medicaid and Medicare, as a means of payment for persons who live outside of the center's service area.

Service Ineligibility: Persons who do not reside within the Center's service area, individuals who do not meet the criteria described above (Service Access) and/or those unwilling or unable to pay for services if/when existing resources cannot support ongoing indigent are ineligible for psychiatric services.

Service Compliance: Regular sessions with the psychiatrist or advanced nurse practitioner are required to evaluate the client on an ongoing basis and address issues including but not limited to the effectiveness of medication, potential side effects to medication, and potential medication interactions. Therefore, it is imperative that clients keep scheduled appointments with the psychiatrist or nurse practitioner.

Unless the client is at risk to themselves or others and too ill to understand his/her need for services, individuals who fail to keep an appointment for a new evaluation will not be rescheduled for 6 months and those who no show the second new evaluation scheduled will not be rescheduled for psychiatric services.

Clients who fail to keep a follow-up appointment will be referred to the open clinic. If the client misses the Open Clinic, meds may not be given (at medical staff's prerogative) and the client should be informed of the next Open Clinic time frame. The client needs to show up and be seen during an Open Clinic before they can return to the regular scheduling.

When a client fails to keep an Open Clinic session, the psychiatrist will assess if this is a client who will deteriorate and need to be hospitalized without medication. If so, the clinic nurse will be asked to arrange for follow-up/outreach. In addition, a letter may be sent to the client, reminding them of the consequences of failing to take medication as prescribed and/or failing to keep scheduled appointments. (Please see Attachment A for a sample reminder letter.)

Unless these is imminent risk for long-term rehospitalization, clients failing to keep 2 open clinics sessions, should be terminated from psychiatric services. Certainly, those not at risk for rehospitalization failing 2 open clinics should be terminated from psychiatric services. If/when the client requests medication in the future; they would be handled as a "new evaluation", subject to the psychiatric scheduling guidelines, including the 6month/1 year wait period for failed new

evaluations. It is understood that some individuals would not meet the scheduling criteria for new clients and could not be rescheduled.

Service Termination: Center physicians have authority for decisions to end treatment of clients under their care. When a psychiatrist determines that it is necessary to end Center psychiatric services as a result of noncompliance, in compliance with the Administrative Code, 4731-27-01, s/he shall send a letter to the client addressing each of these topics:

- Reason for termination of medical services (type of noncompliance, including unable to pay for services)
- "Access" and emergency services during the 30 day period
- Plan for services/Help finding alternate
- Consequences of not getting treatment
- Offer to release treatment records to a new provider

The letter should be sent via certified mail, return receipt requested, and by regular mail. A copy of the letter and return receipt shall be filed in the client's Individualized Client Record.

Please see Attachment B for a sample termination letters.

- If there is documentation that the client has been continuing to receive medication, prescription for a 30 day supply of medication may be written and enclosed with the letter (Attachment B1).
- If the client has been receiving prescriptions for a Category II medication or there are any concerns regarding mailing the prescriptions, the client should be asked to come in to the clinic and pick up his/her prescriptions (Attachment B2).
- In the case that the client has stopped taking medication for a period of time or the prescriptions previously written are no longer appropriate, further prescriptions would not be written but the client would have access to psychiatric services for an additional 30 day period (Attachment B3).

The psychiatrist will notify the Site Director of termination of psychiatric services. Notice will include a recommendation regarding continuation or termination of other Center services. The authority to terminate other, non-psychiatric services lies with the Site Director in consultation with the treatment staff members who have rendered care to the client.

Service Documentation: Documentation of the provision of psychiatric services shall be completed and filed in the individual client record (ICR).

Documentation of the initial psychiatric assessment and evaluation shall include a history of present illness, past psychiatric history, substance abuse history, medical history, family history, psychosocial history, mental status examination, diagnostic impression, current medications and a summary which indicates immediate treatment plans with a rationale for any medication prescribed and laboratory tests ordered. (Please see Attachment C for the required format.)

Documentation of follow-up evaluations shall include an encapsulated summary of medication changes or other major changes in treatment from the previous, appointment followed by significant changes in the client's symptoms and general functioning since the last appointment, screening for dangerousness, diagnostic impression, medications and a summary which indicates rationale for any medication changes and documents any laboratory results being discussed with the client. (Please see Attachment D for the required format.) Documentation of a no-show shall include the recommended disposition, such as request for outreach, termination of psychiatric services, etc. This documentation may be completed on the applicable session note or an interval note.

DAY TREATMENT (PARTIAL HOSPITALIZATION)

Day Treatment services are designed to provide both rehabilitation and maintenance services to residents of this service district. Services are provided 3-6 hours per day and rely on a milieu approach to mental health treatment. Treatment modalities include group psychotherapy, art and music therapy, activity and recreation therapy, health and sex education, daily living skill building and creative writing. Activities are structured and goal oriented. Client's strengths, needs and individualized goals are established via the individualized service plan and evaluated on a weekly basis. The collective energies of the group of clients and staff are directed toward helping each client to identify and reach realistic goals through the therapeutic milieu. The staff, group and program components function to assist and support goals accomplishment.

Clients served are primarily SMD adults (18 or more years old). Adults receiving this service have needs for more structure than what can be provided in the natural environment, but less than what would be provided in an inpatient psychiatric setting. Day Treatment provides an alternative to inpatient hospitalization. It addresses the need for resolution or stabilization of short term problems or crisis situations for de-compensating psychiatric or behavioral conditions that if not interrupted or ameliorated, would require 24-hour hospitalization. In addition, Day Treatment assists persons in the transition to community living and serves to maintain clients in the community. It also provides an intense form of outpatient treatment to maximize the ability of persons with severe and chronic psychiatric disabilities to achieve optimal functioning in the community.

This service is defined and delivered in compliance with guidelines that are specified in the Ohio Department of Mental Health Certification Standards. Day Treatment services are provided in coordination with the client's ISP.

Targeted Population for Day Treatment Services: Adults receiving this service have needs for more structure than what can be provided in the natural environment, but less than what would be provided in an inpatient psychiatric setting. Day Treatment provides an alternative to inpatient hospitalization. It addresses the need for resolution or stabilization of short-term problems or crisis situations for decompensating psychiatric or behavioral conditions that if not interrupted or ameliorated, would require 24-hour hospitalization. In addition, Day Treatment assists persons in the transition to community living and serves to maintain clients in the community. It also provides an intense form of outpatient treatment to maximize the ability of persons with severe and chronic psychiatric disabilities to achieve optimal functioning in the community.

Severely mentally disabled (SMD) adults shall receive priority in service provision.

Day Treatment Service Organization: Each clinical site that is accredited and certified to provide Day Treatment for adults shall have a schedule of activities for Day Treatment Services, specifying the goals and time frame for each activity facilitated during the service day.

The Day Treatment schedule shall accommodate varying client needs for the level of intensity and amount of service required. (For example, some clients may require three, six hour days per week while others may only need one, three hour day per week.) Components shall be designed to address the following goals:

- Improve community living, activities of daily living and life management skills;
- Promote understanding of mental illness and symptom management;
- Promote responsibility and motivation;
- Improve self-concept, self-esteem, self-image and congruency of mood and affect;
- Promote goal setting;
- Enhance understanding and insight;
- Improve coping, problem solving and decision making skills;
- Improve attention span, listening, concentration and memory skills;
- Improve communication skills, including verbal and nonverbal self-expression (assertive vs. aggressive expression), group and interpersonal relationships, self-disclosure, conflict resolution, etc.;
- Promote orientation, awareness and interest in surroundings, community and current events;
- Develop leisure skills, encourage creativity and spontaneity;
- Promote cohesiveness and encourage cooperative working relationships;
- Improve stress management skills, including the reduction of physical tension,
- Develop skills needed to improve adaptation to school, home and work environment.

Components shall be planned in a fashion which affords an appropriate balance in the levels of intensity throughout the Day Treatment day. (For example, Group Therapy might be followed by Exercise / Movement.)

Components shall be planned in a fashion which assures the required level of intensity or the Day Treatment Service.

Clients cannot receive more than one mental health service during the same service hour. Therefore, other necessary mental health services (such as CPST) cannot be provided during the scheduled Day Treatment day or session. These services may be provided before or after the scheduled session.

Referral for Day Treatment Services and Linkages with Other Center Service Providers: When the need for Day Treatment Service is identified, the primary CPST provider (or other Center service provider) will complete the referral section of the Day Treatment Referral and Assessment Form and forward it to Day Treatment staff. If the record is not maintained at the site where Day Treatment Services will be provided, copies of the current ISP and the most

recent psychiatric progress notes will be included. Within 3 working days Day Treatment staff will schedule an interview with the client to determine client need for service client goals for the service. Day Treatment staff will estimate the length of time the client will need to participate in the service and the days and times the client will be scheduled to participate in the service. Based upon their individual needs and requests, clients may be scheduled to attend less than 4 days per week. The primary CPST provider may be asked to participate in the interview. Accommodations shall be made to assure that immediate Day Treatment Services are provided when indicated by client need.

Day Treatment staff will complete the disposition and treatment plan section of the Day Treatment Referral and Assessment Form and forward it to the primary CPST provider (or other Center service provider). The primary CPST provider will review the Day Treatment Referral and Assessment Form and make any needed revisions in the ISP to assure that client goals specific to the provision of Day Treatment are documented. The Day Treatment Referral and Assessment Form shall be filed in the individualized client record (ICR).

Day Treatment and CPST staff will maintain regular contact to discuss progress or lack of progress in relation to client goals, continued need for Day Treatment Services and the need for other or additional mental health services.

Day Treatment staff shall assure that Day Treatment Daily Progress Notes is completed and filed in the ICR of all clients participating in the service and that the Day Treatment Service Termination/Continued Length of Stay Review Form is completed when services are terminated and at least annually.

Day Treatment Staff Responsibilities: The responsibilities of the Day Treatment staff shall include but may not be limited to the following:

1. Assures that the Day Treatment sessions are 3-6 hours per day for adults occur on a on a regularly scheduled basis;
2. Assures that a Day Treatment schedule of activities which meets the specified protocols is developed, revised as needed, and posted for staff and client reference;
3. Accepts and screens referrals to determine client need for Day Treatment Service, client goals for the service and anticipated length of stay in the service;
4. Makes client assignment for days and hours of participation in the Day Treatment Service;
5. Makes arrangements for any transportation which may be needed by the client for participation in the service;
6. Forwards referral / assessment form to primary CPST provider (or other Center primary provider);
7. Makes referral for community support program services if the need for these services is identified and the client does not have a primary CPST provider assigned;
8. Maintains regular contact with the primary CPST provider (or other Center provider) to discuss progress or lack of progress in relation to client goals, continued need for Day Treatment Services and the need for other or additional mental health services;
9. Builds and maintains a therapeutic relationship with individual clients as well as the group of individuals participating in the service;

10. Promotes group cohesion;
11. Maintains knowledge of basic history, assessments, support systems, and strengths and needs of the clients participating in the service;
12. Reviews individual client's participation in the service on a regular basis to determine ongoing need for the service, length of stay in the service, and progress or lack of progress towards goals; and
13. Assures that documentation of service provision is completed and filed in the ICR.

Documentation of the Day Treatment Service shall include an assessment of the client's functioning and participation in the service, other significant events and behavioral observations regarding the client's ability to function away from the service.

Primary CPST Provider (Or Other Center Primary Service Provider) Responsibilities: The responsibilities of the Primary CPST Provider or Other Center Primary Service Provider shall include but may not be limited to the following:

1. The responsibilities of the primary CPST provider (or other Center primary service provider shall include but may not be limited to the following:
2. Makes referrals for Day Treatment Service when indicated by client need by completing referral section of the Day Treatment Referral and Assessment form and forwarding it with a copy of the current ISP to Day Treatment staff;
3. Participates as requested in the client interview to determine the need for Day Treatment Service;
4. Reviews referral form following assessment for Day Treatment Service to determine disposition and contacts Day Treatment staff with any questions regarding disposition, established goals, anticipated length of stay or scheduled days and times of participation;
5. Reviews current ISP and makes any needed revisions in the ISP to assure that Day Treatment Service and client goals for participation in the service are incorporated;
6. Maintains regular contact with the Day Treatment staff to discuss progress or lack of progress in relation to client goals, continued need for Day Treatment Services and the need for other or additional mental health services;
7. Maintains a therapeutic relationship with the client;
8. Maintains knowledge of client's history, assessments, support systems, and strengths and needs;
9. Provides or ensures the provision of all necessary CPST services; and
10. Reviews the client's ongoing need for the service, length of stay in the service, and progress or lack of progress toward goals on a regular basis.

CRISIS INTERVENTION/ PRE-HOSPITALIZATION SCREENING

Crisis intervention services are immediate interventions (that may include, but are not limited to active listening, reassurance, information and linkage to community resources) with persons who have an urgent need for mental health services due to psychosis, suicidal ideation or other crisis situations. These services are available 24-hours per day in a variety of settings that include agency offices, hospital emergency rooms, jails and the home as may be deemed appropriate.

The objective is to address the needs of the crisis within the framework that contributed to its development and when necessary to safeguard the welfare of the client and community. Appropriate crisis intervention may result in an overall improvement in the conditions that may result in an overall improvement in the conditions that created the crisis and eliminate a potential need for psychiatric hospitalization or other restrictive measures.

Crisis Intervention services are provided by a variety of licensed mental health professionals and trained others in accordance with ODMH provider qualifications.

Pre-hospitalization Screening involves the assessment of a person's need for psychiatric hospitalization and is a facet of the emergency services program. It may be provided to a person of any age who is undergoing a psychiatric crisis. Assessments may occur in a variety of settings that include agency offices, jails, courts, hospitals or natural settings as may be deemed appropriate. Pre-hospital screenings are always done face to face. Objectives are to ensure that least restrictive settings for treatment are considered and appropriately used in the service of persons undergoing acute exacerbation of psychiatric symptoms and to protect client and societal welfare by referral to psychiatric facilities (public and private) when it is necessary.

Only persons who are qualified in accordance with ODMH provider qualification standards provide this service. This service is accessible at each satellite clinic.

Eligibility Criteria: Any person who is a resident of the service area or who is in the service area is eligible to receive this service. Crisis Intervention services are provided to individuals that have an urgent need for mental health services due to psychosis, suicidal ideation or other crisis situations. Persons are discharged from the service when the crisis situation is stabilized and/or referrals are made for longer-term resolution of the issues that have brought on the crisis. Persons in crisis can receive Crisis Intervention Service without regard to ability to pay.

Ineligibility Criteria: Any person who resides in the service area or is in the service area is eligible for Crisis Intervention Service. Center staff does not leave the service area to provide Crisis Intervention to a person who does not reside in the service area.

Service Coordination: The Center's Emergency Services Program is available and accessible to all individuals 24 hours per day, 7 days per week. Emergency Service Program staff will make every effort to assure continuity and coordination with other service providers. To initiate coordination of a client's use of the Emergency Service Program, the clinician contacts Emergency Services Program staff to review the case. A short-term treatment plan (available on the Forms Download and Print Intranet Webpage) will be completed for regular callers/service utilizers. A copy of the plan will be posted in the Martha Cottrill Clinic and the local Clinic's phone room in a confidential area accessible to the volunteers and a copy will be filed in the client's individual client record (ICR). Emergency Services Program staff will provide the clinician with information and feedback pertinent to any contacts with the client. A copy of the Emergency Services contact sheet will be filed in the ICR.

Documentation of Emergency Services Contact: A Contact Summary Form will be completed for all contacts with the Emergency Services Program. Disposition of the Contact Summary will be as follows:

Client Contacts: A copy of the Contact Summary will be filed in the ICR in compliance with the Filing Process Procedure (05-02-02).

Anonymous Contacts: The Contact Summary shall be kept for a period of six (6) months.

Non-Client Contacts: The Contact Summary of non-clients with known caller names shall be kept for a period of two (2) years.

Repeat Callers: The Contact Summary of repeat callers who have called within the prior six (6) months and are not admitted clients shall be kept beyond a two (2) year period provided the client has made a contact within the past six (6) months.

Contact Summaries subject to destruction shall be shredded and disposed of in the manner prescribed for confidential records.

Crisis Respite: When respite services provided by the Floyd Simantel Clinic are not available, accessible or appropriate, respite care may be provided by the Emergency Services Program in the Martha Cottrill Clinic for the purpose of crisis stabilization for individuals experiencing psychological stress and emotional dysfunction. The intent of respite care is a brief (1-3 days) but intensive modality that provides shelter and supervision for persons in crisis to help stabilize functioning to the pre-crisis level. Priority shall be given to individuals at risk for psychiatric hospitalization, potential suicidal clients, persons experiencing adverse drug reactions, and victims of domestic violence.

The decision to accept an individual for respite care and the development of a short-term treatment plan will be the joint responsibility of the Emergency Services Program staff and the referring clinician or back-up staff with final approval from the Emergency Services Coordinator. During non-business hours, the final decision for accepting a client into respite rests with the back-up staff that will assess the appropriateness of the client for volunteer supervision. The referring clinician or back-up staff is responsible for arranging transportation, verbally communicating the treatment plan to be followed to the volunteers on duty and assuring that the plan is documented and posted appropriately the following business day. To assure continuity of care and prompt relocation of the client, arrangements for follow-up will be the responsibility of the originating County. Emergency Services staff will be responsible for communicating needed information regarding the client to the appropriate staff in the originating county.

Professional Back-Up Staff: Professional Back-up staff shall be on call for emergencies 24 hours a day, 7 days a week.

1. During regular Clinic hours, back-up services are provided by the Emergency Services staff and clinic staff.

2. Back-up services are provided by clinic staff members from 5:00 p.m. to 8:00 a.m. the following day, Monday through Thursday, and from 8:00 a.m. to 8:00 a.m. on weekends (Friday through Monday) and on holidays.
3. When requested, the back-up staff will provide assessment or prescreening for psychiatric hospitalization.
4. The back-up staff acts as a consultant to the Emergency Services staff and volunteers, as a consultant to local emergency room and law enforcement personnel, and as a face-to-face outreach service to community members.
5. The back-up staff provides assessment and crisis intervention to community members at the request of the emergency room or law enforcement personnel or at the request of Emergency Services staff and volunteers.
6. Back-up staff are required to respond to the emergency room and/or local law enforcement agencies. Transportation of clients is at the discretion of the back-up staff; however, agency courier shall be used when clinically appropriate.
7. Back-up staff are expected to respond to a face-to-face outreach request within forty-five (45) minutes. If the response time exceeds this, notification will be made to the requesting source. In no instance is response time to exceed one hour.
8. Back-up staff must be employees of the Center or have contracts with the Center and in a position of providing clinical services.
9. Back-up staff must complete back-up training provided by the Center.
10. Back-up staff must have a reliable means of transportation.
11. Back-up staff must have a cell phone.
12. Back-up staff must complete and submit all required documentation on the next business day.
13. If during weekdays the back-up staff is presently engaged or cannot be contacted, the back-up staff person's supervisor is the next person to be contacted. If during a weekend or holiday the back-up staff cannot be contacted, the other county contract back-up staff is the first person to be contacted. From there, responsibility for handling the request goes to any of the Clinic back-up staff.
14. Back-up services are a professional service provided by the Center and a responsibility shared by all clinical staff.

COMMUNITY PSYCHIATRIC SUPPORTIVE TREATMENT

Community Psychiatric Supportive Treatment (formerly Community Support Service) is a diverse group of supportive activities directed toward assisting clients in meeting their social, vocational, economic, medical and physical needs in order to maximize the individuals functioning within the least restrictive environment. Community Psychiatric Supportive Treatment is considered an essential service for all Severely Mentally Disabled/Severely Emotionally Disturbed (SMD/SED) clients and may be delivered on an as needed basis to clients who do not fit the definition of SMD/SED but have a demonstrated need for the service. Major components of Community Psychiatric Supportive Treatment include: coordination of assessments, treatment planning and crisis assistance services; linkage and training for persons served in the use of community resource, social skill development, facilitation of skills that enhance independent living and overall monitoring of service delivery.

Community Psychiatric Supportive Treatment may be delivered at any agency site, natural

setting or community agency, based on client need. Providers meet eligibility criteria as listed in the ODMH Certification Standards.

Targeted Client Population for Community Psychiatric Support Treatment Program Services: Clients who are identified as having a severe mental disability (SMD) or serious emotional disturbance (SED); clients receiving partial hospitalization, residential treatment and/or medication-somatic services; and clients identified in need of community rehabilitative treatment activities shall receive CPST services. An exception to the requirement for CPST service provision can be made if the client refuses the service or if it is determined that other mental health services are more clinically appropriate and the exception is adequately documented in the ISP.

Clinic and Program Directors shall take steps necessary to assure the ongoing availability and accessibility of CPST services for all clients requesting the service, which is subject to the availability of the Center's financial funding resources. SED children and adolescents in out-of-home placements, SMD adults in psychiatric hospitals, and SMD adults who are homeless or at risk for being homeless, shall receive priority in CPST service delivery. Center staff will assure coordination with family and significant others and other components of the system of care such as education, juvenile justice, mental retardation developmental disabilities and children's services in providing CPST services for children and youth.

Service Ineligibility: Persons who do not reside within the Center's service area, individuals who do not meet the criteria described above (Targeted Client Population for CPST Program Services) and/or those unwilling or unable to pay for services if/when existing resources cannot support ongoing indigent are ineligible for CPST services.

Community Psychiatric Support Treatment Program Providers and Training: Each Center service site shall have a Community Psychiatric Support Treatment Program with staff designated as Primary Community Psychiatric Support Treatment Program Providers. Primary CPST Providers will be at least 0.5 FTE employees who spend at least 50% of their time providing and/or supervising CPST services.

All clients receiving CPST services shall have an assigned Primary CPST Provider. Responsibilities for the Primary CPST Provider include but may not be limited to the following building and maintaining a therapeutic relationship with the client; providing or ensuing the provision of all necessary CPST services; knowledge of client history, assessments support system, strengths and needs; establishing service goals and reviewing progress towards goal achievement with the client; and assuring required information and documentation is maintained in the Individual Client Record (ICR). Consistent with the Center's team approach to CPST services, the Primary CPST Provider may designate the provision of CPST activities to other qualified Center employees. This designation as well as the name of the Primary CPST Provider, must be indicated on the ISP.

The Center will develop and implement a CPST training plan each fiscal year (See 04-11-01 Annual Staff Development Plan). Primary CPST providers will participate in agency CPST training to assure that SMD adults, SED children and adolescents, and their families receive

quality mental health services. Additionally, Primary CPST Providers shall participate in supervision according to a schedule that is determined by the supervisor and is consistent with the employees' qualifications, experience and other clinically relevant issues such as client need, risk management and quality assurance.

FORENSIC EVALUATION

The Center's Forensic Evaluation Service addresses the needs of the SMD population in the criminal justice system. The objective is to ensure that persons who have severe mental illnesses are held accountable for their behavior in the community while at the same time assisting the system with delineating those SMD persons who might be better served by treatment rather than incarceration. Most frequent services provided within Forensic Evaluation include diagnostic assessment, and evaluations for competency to stand trial and not guilty by reason of insanity. The purpose is to make recommendations to local criminal justice systems so that appropriate treatment plans can be established. Forensic services are provided to jails, municipal courts and other components of the criminal justice system that are outside of the scope of services. At this time, the Agency utilizes a Forensic Psychologist who services are utilized through contract.

Other needs of the criminal justice system that may also be addressed by this service include; domestic violence evaluations, assessment of competency to be a witness, assessment related to psychological effects of an act upon a victim and other types of assessments as are defined under 5122-29-07 of the ODMH Certification Standards.

This service is provided in accordance with ODMH Provider and Service Standards.

HOTLINE

The Center's Hotline Service is an important component of the overall emergency services system. Foreign exchange lines connect all parts of the five county service area with toll free service to the Center's crisis center. Trained volunteers answer the crisis line and are backed up 365 days per year by professional staff of the Center on an outreach basis. The Hotline is also accessible to the hearing impaired through a TDD unit. This service may be provided to any person in the service district who is experiencing a crisis. Needs met include; assistance with crisis management, suicide prevention intervention, linkages to needed resources and community agencies, information and referral, and linkage to psychiatric and medical services when necessary. The crisis center maintains a list of housing placements so that emergency housing can be easily accessed in conjunction with the crisis emergency service.

This service is provided in accordance with ODMH standards that relate to service guidelines and provider qualifications.

SOCIAL AND RECREATIONAL SERVICE

Social and Recreational Services have been developed with consultation of persons served and are provided in accordance with client’s needs. The objective is to meet the socialization needs of the SMD population that are not addressed in Day Treatment. Frequently clients served in this service are those whose level of functioning is at either side of a continuum. That is, clients

whose functioning is impaired to the extent that they are unable to tolerate a 3-6 hour group or clients who no longer need the structure of Day Treatment, but who still express a need to socialize with persons who have experienced a severe mental disability. Social and Recreational services may be provided at community locations such as nursing homes and community centers or at satellite locations. Activities may include social gatherings, sing-a-longs, bowling or other events that provide an opportunity for enhanced socialization.

Social and Recreational services are provided in accordance with ODMH Service and Provider Standards. It is also noted that many satellite clinics in the Center's service district are viewed as community meeting facilities. This is due to a concerted effort that has been made to allow community groups to use Center buildings for public meetings. This has significantly reduced the stigma that is often associated with community mental health center buildings. For this reason SMD persons frequently request that Social and
Recreational services be provided at Center locations. Social and Recreational Service is available Monday through Friday between the hours of 8:00 a.m. and 5:00 p.m. Satellite clinics and residential centers may also make this service available at other times as may be determined by group needs. This service may be accessed at each of the satellite clinics and residential centers based on client needs.

MENTAL HEALTH PREVENTION (DIVERSION)

Mental Health prevention services are designed to enhance protective factors for mental health and reduce risk factors for mental health problems, including stigma. Mental health prevention services include targeted prevention programs designed to reduce the incidence, prevalence or severity of mental or emotional problems and structured educational programs designed to increase knowledge of or change attitudes about mental health problems, needs and services.

Mental Health Prevention (Diversion) service strategies include: consultation, prevention and mental health education.

CONSULTATION

Consultation services are provided to an individual served by another system or to another system. The purpose is to evaluate the mental health needs of persons who are being served by another system; assess the system’s ability to meet the needs that have been identified and to assist in the process of amending services or ensuring that appropriate referrals are made. Consultation may also be directed at a group or special population served by another system. In this sense consultation may be focused on the clinical condition of the individual or on the functioning and dynamics of the system.

Consultation services are provided according to priorities established to produce the greatest benefit in meeting the mental health needs of the community. Priority systems include schools, law enforcement agencies, jails, courts, human services, hospitals, hospital emergency rooms, children's services agencies, employers and other systems involved concurrently with persons served in the mental health system. The determination of these community organizations and their mental health consultation needs is determined by individualized surveys conducted by staff

members and directors via Clinic Quality Circles. Consultation services are provided in accordance with service
and provider guidelines as are written in the ODMH Certification Standards.

PREVENTION

Prevention services represent a range of services that are identified as community priorities by needs assessments. These may include: competency skills building, stress management, self-esteem building, mental health promotion, lifestyle management, and ways in which community systems can meet the needs of their citizenry more effectively. The purpose of this service is to work conjointly with community agencies and persons to build personal and community systemic strengths such that the incidence of mental health and substance abuse problems is reduced. Prevention programs are planned for groups, upon requests that may be processed at any of the Center's locations. Programs may be provided at agency facilities or at a variety of community sites. Effectiveness of prevention services is assessed via the Scioto Paint Valley Mental Health Center Prevention Evaluation form or, for more targeted programming, more extensive outcomes measures, including but not limited to the ODMH Ohio Scales.

MENTAL HEALTH EDUCATION

Mental health education services are provided on a community basis and focus on educating persons who have been touched by mental illness and community members, at large, about mental health issues and/or services. This service may also be provided to groups or an individual who represents a group. This service may also be provided at community meetings when the Center is represented for the purpose of providing information about mental illness or mental health services that are available in the community. The purpose of this service is to meet community needs that relate to education about mental illness, treatments that are available and the necessity of reducing stigma so that persons affected by mental illness, and their significant others, may lead meaningful lives in the community. Persons served family members and significant others are included in the planning and implementing of this service. The vast majority of services delivered in this area are delivered at the request of persons served and are specifically designed in response to persons served planning needs and evaluation.

Admission Criteria and Discharge Criteria: Mental Health Prevention (Diversion) services are characterized by the population(s) they are designed to impact. Universal prevention services are targeted toward the general population in the Center’s five-county service area. Any resident of the Center’s service area or any person who is in the Center’s service area is eligible to receive this service. Selective prevention services are aimed toward target populations within the general population where risk is greater and may include at-risk children and youth, non-using children of substance-involved parents, Head Start participants, first time youthful offenders, etc. Indicated prevention services are targeted toward high-risk individuals who are not currently in need of treatment.

For further information about target populations for specific mental health prevention programming, please see the Mental Health Prevention Plan.

EMPLOYMENT/VOCATIONAL SERVICE

Employment/Vocational services are provided at the Floyd Simantel Clinic, 312 East Second Street; the Martha Cottrill Clinic, 4449 State Route 159, Chillicothe, Ohio 45601; the Greenfield location, 315 South Washington Street, Greenfield, Ohio 45123; the Fayette County Clinic, 1300 East Paint Street, Washington Court House, Ohio 43160; the Highland County Clinic, 108 Erin Court, Hillsboro, Ohio 45133; the Pickaway County Clinic, 145 Morris Road, Circleville, Ohio 43113 and the Pike County Clinic, 102 Dawn Lane, Waverly, Ohio 45690. Services are provided as scheduled during each clinic's usual business hours, Monday through Friday 8 AM – 5 PM.

The purpose and intent of Employment / Vocational services is to promote recovery by assisting consumers in securing and/or maintaining employment by providing training and skill development that is goal oriented, ability based and incorporates individual choice. Anticipated outcomes of the service include the consumer obtaining and/or maintaining employment, learning new job skills, increasing self-sufficiency and contributing to the community.

Employment/Vocational services consists of assessment, job finding and supportive employment services specific to the individual consumer requests, choices and needs. In addition to individual choice and consumer strengths, the assessment may also include any of the following: skills, employment history, education, needs, job market / career exploration, limitations, benefit analysis, individual resources, transportation and vocational plan. Supportive employment services may include any of the following: job coaching, job placement, community assessment, job development, follow-up, job seeking and keeping skills, job club, work enclaves, volunteer community employment, benefits counseling, peer support, networking and training. The rationale for the provision of Employment / Vocational service is incorporated into the consumers Individualized Service Plan.

Employment / Vocational services are supervised and provided by qualified individuals in compliance with the Ohio Department of Mental Health Certification Standards for Community Mental Health Agencies, Administrative Rule 5122-29-11.

REFERRAL & INFORMATION SERVICE

Referral & Information Service is a service that is designed to provide referrals and information about mental health and other community services to persons in the community. Referral & Information Service is provided in cooperation and coordination with other community agencies. The service is primarily provided by telephone and is accessed through the Center's FX lines that are in each county, within the Service District. Referral & Information Service may also be accessed by persons who walk-in to the Center's Crisis Center. Persons providing this service make referrals by providing telephone numbers and hours of operation or by contacting the referral agency/provider directly, to secure services. The Center serves as the 2-1-1 line for all five counties.

The following FX lines are used to access Referral & Information Service:

Ross	(740) 773-4357
Fayette	(740) 335-7155
Highland	(937) 393-9904
Pickaway	(740) 477-2579
Pike	(740) 947-2147

These numbers are accessible by TDD for persons who are hearing impaired.

OTHER MENTAL HEALTH SERVICES

The Paint Valley Alcohol, Drug Addiction and Mental Health Services Board funds residential services provided by Scioto Paint Valley Mental Health Center. This includes **Residential Treatment and Residential Support.** As of FY 11, the Center is no longer able to provide Housing Assistance Program due to budgetary cuts from the Paint Valley ADAMH Board.

RESIDENTIAL TREATMENT

Scioto Paint Valley Mental Health Center is licensed by the Ohio Department of Mental Health (ODMH) to operate a Type 1 Residential Facility. The Floyd Simantel Clinic located at 312 E. Second Street in Chillicothe, Ohio is licensed for 18 adult beds. The facility continues to operate in full compliance with ODMH Rules on Licensure for Residential Facilities.

Staff training is an ongoing process consistent with the Residential Training Manuals approved for each site at the time of re-licensure in 2011.

The Residential Facility utilizes client satisfaction surveys as a mechanism to solicit and receive feedback about the quality of the service from persons served.

Admission Criteria: Residential treatment is provided to those:

1. Men and women who are at least 18 years of age.
2. Who are residents of the Center's service area.
3. Who are ambulatory and capable of performing activities of daily living skills.
4. Who are in good health excluding their need for skilled or inter-immediate nursing care.
5. Who do not present a significant risk of harm to or impediment to the treatment of current residents.
6. Who are experiencing an acute phase of emotional and mental dysfunction which cannot be managed in the residential setting, including the ability to reasonably control impulses towards self, others and property.
7. Who need intensive treatment that can only be provided in a residential treatment.

8. Who need temporary care and treatment with the goal of learning to function as independently as possible within the least restrictive environment.

9. Who need to inculcate motivation to persevere and remain involved with life.

10. Who have not achieved a level of functioning that enables him/her to meet the social, emotional and behavioral expectations of the community.

11. Who have a mental health diagnosis that has resulted in a loss of functioning.

12. Who are not severely agitated, present an immediate danger to others or would require physical or medical restraints.

13. Who are experiencing suicidal ideation, requiring medication stabilization or needing a time-out from environmental stresses.

14. Who are at risk for psychiatric hospitalization or are returning to the community from psychiatric hospitalization and residential services provides a less restrictive alternative to a longer inpatient stay.

Referral Process: Referrals will be accepted from Center workforce members. Direct referrals from external sources cannot be accepted. All individuals being referred from external sources, including hospitals, physicians, family members, etc. must be assessed by a Center workforce member prior to the referral being made.

The Center workforce member will contact the FSC with referral information and complete the FSC Residential Referral Form (Attachment A).

An FSC workforce member will document the referral information. Based upon review of the referral information, an FSC supervisor will make a decision regarding accepting the referral for admission. The referring workforce member will be contacted in a timely manner, typically within 1 hour or less, regarding the referrals acceptance or refusal.

If the referral is accepted, the referring workforce members will arrange transportation to FSC for the individual being referred. The referring workforce member will assure that portions of the individuals record (ICR) be faxed to FSC, including but not limited to the following: diagnostic assessment, health status inventory, individualized service plan (ISP), medication record, and psychiatric progress notes.

To the extent possible, the referring clinic will assure that the individual being referred has been admitted as a Center client, has a completed diagnostic assessment and has a current ISP. When this is not possible (i.e. referral made for non-clients during non-business hours), FSC workforce members will assure that the individual is admitted as a Center client and that the diagnostic assessment and ISP are completed on the next business day.

Upon arrival to FSC, a workforce member will assist the client in completing the Residential Treatment Agreement (Attachment B), HIPAA Privacy Notice and Rights Receipt (Attachment C and D), Client Orientation Checklist (Attachment E), and Residential Acknowledgement Form (Attachment F). The workforce member will assist the client in establishing residential treatment service goals and objectives (Attachment G) and in orienting to the facility by completing the Residential Admission Checklist (Attachment H) and reviewing with the client the FSC Guidelines (Attachment I) and What Is Partial Hospitalization (Attachment J).

In the case that residential services exceed a fourteen (14) day period, the client's ICR and primary responsibility for all client services will be transferred to FSC.

Discharge Planning Process: FSC workforce members will work with the client and referring clinic to establish discharge plans. Upon discharge, FSC workforce members will ensure that appropriate appointments for any needed ongoing services are scheduled and communicated to the client. The FSC workforce member will ensure all clinical information and documents, including the ICR and primary service responsibility, is transferred to the appropriate clinic. Upon discharge, FSC workforce members will complete the Residential Discharge Plan and Treatment Summary (Attachment K), and the Residential Discharge Checklist (Attachment L).

RESIDENTIAL SUPPORT

Scioto Paint Valley Mental Health Center's Transitional Services Program located at the Floyd Simantel Clinic at 312 East Second Street in Chillicothe, Ohio assists severely mentally disabled adults to move toward independent living in the community in each of the counties of the catchment area (Fayette, Highland, Pickaway, Pike and Ross). This is accomplished by linking consumers with a residential support opportunity that best meets the individualized request and need. Residential support options include *Adult Care Facilities* and linkage with *community housing opportunities* facilitated in conjunction with intensive Community Psychiatric Supportive Treatment (CPST) services.

Adult Care Facilities (ACF's), licensed by the Ohio Department of Health (ODH) provide room, board and personal care. This is sometimes a good option for consumers who require 24-hour supervision and personal care but less structure and mental health service then provided by the Center's adult residential treatment facility. ACF's are located in each of the 5 counties in the Center's service area. Consumers residing in Adult Care Facilities receive CPST, Pharmacological Management, Day Treatment , Behavioral Health Counseling and Therapy and/or other mental health services from the local clinic as indicated on the consumers Individualized Service Plan. In many cases, individuals placed in ACF's have Residential Support Supplemental (RSS) funds. The Center has a reimbursement agreement with an ACF operator in 4 of the 5 counties in the Center's service area and as resources permit, pays all or a portion of the residential fees when the consumer is unable to do so. In addition to mental health education provided directly to operators and staff in the ACF's on an ongoing basis by CPST Providers, the Center facilitates group training for all Operators of Adult Care Facilities in the service area on at least an annual basis. All ACF's participating receive a videotape of the training. ACF operators and staff are encouraged to contact the Center's 24/7 crisis line when

consultation and/or assistance is needed during nonbusiness hours. Feedback is solicited and received about the quality of the AFC from consumers by Center CPST Providers, RSS Case Managers and ODH surveyors.

Linkage with *community housing opportunities* facilitated in conjunction with intensive CPST services assists consumers who require a high level of CPST services, monitoring and assistance (nonbillable CPST) but less structure and personal care services than is provided by an ACF or the Center's adult residential treatment facility. While the need continues to exceed the resource, a variety of safe, affordable community housing opportunities coupled with intensive services is available and accessible to individuals with severe and persistent mental illness. In some cases, consumers share living space (i.e. several consumers may share a house or an apartment) and pool their resources to pay for rent, food, etc. Some consumers prefer residing alone and are more appropriate for a single apartment living situation. In all cases, consumers receive a high level of monitoring and assistance from CPST providers who are immediately available 24/7. As resources permit, consumers may have their rent subsidized by the Center, the Housing Assistance Program or the local Public Housing Authority (PHA). Rent subsidy is in almost all cases crucial to consumers maintaining safe, affordable housing. The HUD 52580 form Inspection Checklist is utilized to evaluate the housing opportunity (house, apartment, etc.) for safety and adequacy prior to the consumer moving in, prior to the provision of any subsidy, as needed or requested and at least annually. Compliance with these criteria assures a smooth transition to local PHA Section 8 Tenant Based Assistance, Rental Certificate Program or Rental Voucher Program. Feedback is solicited and received about the quality of the community housing opportunity from consumers by Center CPST Providers and Transitional Services Supervisors.

The Transitional Services Program is directed and managed by an independently licensed social worker. Program supervisors include a nurse and social worker. These individuals were educated well beyond basic orientation and training regarding basic information about mental illness and/or emotional disturbance and as supervisors are well aware of how to obtain assistance from the Center's as well as numerous other systems of care.

SUBSTANCE ABUSE PROGRAM

PURPOSE, PHILOSOPHY, GOALS AND OBJECTIVES

The Scioto Paint Valley Mental Health Center has been designated, in the Paint Valley Mental Health, Alcohol and Drug Addiction (ADAMH) Board Community Plan, to meet the mental health (including substance abuse) needs of the five county service district. The Boards' service district includes Fayette, Highland, Pickaway, Pike and Ross Counties. The Center's purpose, goals, objectives and service philosophy have grown out of needs assessment activities conducted by the Board and the Center over the past 30 years. Needs assessments are conducted on an ongoing basis so that Center goals, objectives and services can be amended to reflect changing community needs.

The mission/purpose of the Center is defined by the Center's Board of Trustees and reflects community substance abuse treatment, education and prevention needs identified in the ADAMH Board Community Plan. The mission of the Center is to provide leadership and services in a community-wide effort to foster positive, optimal mental health and to assist the community to find ways to prevent, reduce and minimize the residual effects of mental health problems. In keeping with the Center's mission, the Substance Abuse Program proposes to provide leadership and services in the provision of substance abuse treatment, education and prevention services to the residents of Fayette, Highland, Pickaway, Pike and Ross Counties.

Because the Substance Abuse Program is a component of the Center's comprehensive system of care for the provision of mental health services, the Program follows the service philosophy delineated in the Center's Mental Health Service and Performance Plan. The Program also provides services based on target groups established by the Board of Trustees in conjunction with ongoing assessments of community needs. Current target groups are defined as:

1. Community residents who are severely mentally disabled, at risk of suicide or in danger to themselves or others due to mental illness;
2. Community residents who are experiencing a life crisis, substance use problems, abuse, mental or emotional disturbances which handicaps their functioning in the community.
3. Community providers and employers, the forensic system, victims of disease-related stress (HIV, Alzheimer's, etc.) and community residents with special needs.

The Substance Abuse Program is committed to the provision of outpatient and intensive outpatient substance treatment services to persons and family members in the above categories who also have issues with chemically dependency/substance-abuse. In addition, the Substance Abuse Program provides services to persons that have chemical dependency/abuse as a stand-alone concern when there is significant impairment in social and/or occupational, and/or community functioning. Persons who are significantly at-risk for developing chemical dependency are also eligible for treatment services designed to reduce their risk of disease progression. There is a high priority placed on treating substance using females who are pregnant, substance users whose method of administration involves needle injection, and substance using individuals who are HIV positive or that have AIDS.

The Substance Abuse Program strongly encourages that clients develop and maintain quality sobriety. As such, the program is abstinence-based. The Program follows a Stages of Change framework for developing targeted interventions based on each client's stage of change. Motivational interviewing techniques are incorporated into treatment strategies and interventions. The Program uses other quality-of-life indicators to measure treatment success, including but not limited to changes in family, work, social, psychological and vocational functioning, health status, housing status, academic endeavors, career aspirations, etc.

SUBSTANCE ABUSE SCOPE OF PRACTICE

Providers of substance abuse services shall be certified according to the Ohio Chemical Dependency Professionals' Board and/or shall be licensed by the Ohio Counselors and Social

Workers Board with substance abuse assessment and counseling identified as within their scope of practice. Certified providers of substance abuse services may provide any/all services as designated through the ODADAS certification standards. Licensed providers with substance abuse assessment and counseling listed within their scope of practice may provide any/all services as designated through the ODADAS certification standards. Counselor trainees, social work assistants, and/or students enrolled in an accredited educational institution may provide designated substance abuse services under the supervision of an employee of the substance abuse program meeting State requirements as a supervisor. All clinical documentation completed by chemical dependency counselor assistants and student interns shall be reviewed and countersigned as required by ODADAS certification standards by an appropriately credentialed or licensed practitioner qualified to be an alcohol and drug treatment services supervisor.

ADMISSION AND EXCLUSION CRITERIA

The Admission Criteria is the same as the Mental Health Admission criteria with the addition that because the Substance Abuse Program is abstinence-based, clients are prohibited from having controlled substances in their possession at the Program or while involved in Program activities unless the substances are specifically authorized by a physician for medical care. In addition, no client shall be denied admission to Substance Abuse Program services due to his/her use of prescribed psychotropic medication.

1. Prospective clients of the Substance Abuse Program shall complete a Health Status Inventory and a Substance Abuse Program Screening as part of the Diagnostic Assessment.

2. Given the client's responses to the Health Status Inventory, Chemical Dependency Screening Test and Diagnostic Assessment, the clinician will determine if a DSM-IV Substance Abuse diagnosis is warranted.

3. Any client with a DSM-IV Substance Abuse diagnosis is appropriate for admission to the Substance Abuse Program.

4. Family members who are being negatively affected by another's substance abuse are considered appropriate admissions to the Substance Abuse Program as long as the major focus of treatment is on codependency issues.

5. Clients who have no DSM-IV Substance Abuse diagnosis and/or who are not being affected by another's abuse are not appropriate admissions to the Substance Abuse Program.

6. Clients who are admitted to the Substance Abuse Program shall verify their receipt of a Client Handbook by signing a Verification of Receipt Form. The Client Handbook provides information regarding:
    a. Center Client Rights;
    b. Substance Abuse Program Rights and Responsibilities;
    c. Confidentiality of Alcohol and Drug Abuse Client Records;
    d. Education of HIV Infection, ARC and AIDS; and,

e. Education on Tuberculosis and TB control.

7. The clinician shall complete a Level of Care Admission Determination Form on all clients admitted to the Substance Abuse Program.

8. The clinician shall complete a BH mod data form on all clients admitted to the Substance Abuse Program.

9. When substance abuse services are initiated for clients actively receiving mental health services, the client shall sign a Verification of Receipt of Client's Handbook and Consent to Substance Abuse Evaluation and/or Treatment form. The client shall also complete a Substance Abuse Program screening which the Substance Abuse Program clinician shall review. The Substance Abuse Program clinician shall complete a Level of Care Admission Determination Form and data entered into the BH mod system. The client's Individualized Service Plan shall be updated to include the substance abuse diagnosis (if applicable) and to reflect the provision of any/all Substance Abuse Program services. An Update Ticket shall be completed as clinically appropriate.

INELIGIBILITY CRITERIA

Persons who do not meet the criteria above are not eligible to receive Center services.
Clients, who fail to pay for their share of services on 2 consecutive occasions, will not be scheduled for further services until they pay their outstanding bill or unless there is a compelling clinical reason that is approved by a Center clinical manager. Clients who fail to appear for appointments on 2 consecutive occasions, and do not contact the Center to cancel their appointments, will not be scheduled for another appointment without the consent of their clinician. The exception to out of area service is Crisis Intervention Service. Any person who resides in the service area or is in the service area is eligible for Crisis Intervention Service. Center staff do not leave the service area to provide Crisis Intervention to a person who does not reside in the service area. Specifically:

1. The clinician will evaluate the client and determine whether or not the client requires mental health services rather than substance abuse services.

2. The clinician will discuss the decision with his/her supervisor and both agree that substance abuse referral is inappropriate.

3. The client will be informed of the decision that the substance abuse referral is inappropriate. If the client requests, a letter will be sent to the referring agency explaining the inappropriateness of the substance abuse referral, as well as any other referrals recommended. However, referral may be made for mental health services at the Center.

4. In cases where the clinician contacts the external agency, the client/parent/guardian must sign a release of information form. The clinician then follows the Procedure 05-03-01, Disclosure with Client Consent.

AOD DIAGNOSTIC ASSESSMENT/REFERRAL

Diagnostic assessment is an intensive clinical evaluation that is conducted with all identified clients of the Center. The purpose of this assessment is to ascertain each client's psychological state, purpose of involvement, strengths and limitations, social/occupational/familial levels of functioning, treatment needs, physical needs and cultural characteristics that may be significant. Detailed substance use histories and additional familial information are a routine part of all substance Abuse Program Diagnostic Assessments. Through the Diagnostic Assessment process, a clinical diagnosis is made, services needs are determined and services to be provided are negotiated. Referrals may also be made for internal and external services.

Substance Abuse Program Diagnostic Assessment services are provided at all satellite locations. Providers of this service are individuals who meet criteria stated in the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and Ohio Department of Mental Health (ODMH) certification standards.

AOD CASE MANAGEMENT

AOD Case Management services are those activities provided to assist and support Substance Abuse Program clients in gaining access to needed medical, social, educational and other services essential to meeting basic human needs. Case Management activities include coordinating client assessments, treatment planning and crisis interventions services, providing training and facilitating linkages for the use of community resources, monitoring service delivery, obtaining or assisting individuals in obtaining necessary services (including financial assistance, housing assistance, food, clothing, medical services, educational services, vocational services, recreational services, etc.), assisting individuals in becoming involved in self-help support groups, assisting individuals in increasing social support networks with relatives, friends and/or organizations, assisting individuals in performing daily living activities, and coordinating criminal justice services. Case Management services can be provided in a variety of settings, including agency offices, jails, schools, courtrooms and in the natural environment of the client as clinically indicated and deemed appropriate. AOD Case Management services may also be provided by telephone.

AOD Case Management services are provided at all satellite locations. Providers of this service are individuals who meet criteria specified in the ODADAS certification standards.

AOD CRISIS INTERVENTION

AOD Crisis Intervention services are immediate interventions (including but not limited to active listening, reassurance, information and linkage to community resources) with substance-involved persons who have an urgent need for mental health or substance abuse services due to psychosis, suicidal ideation, withdrawal or other crisis situations. These services are available 24 hours per day in a variety of settings, including agency offices, hospital emergency rooms, jails and homes as clinically indicated and deemed appropriate. The objective of Crisis Intervention services is to address clinical needs that precipitated the crisis and, when necessary, to safeguard the welfare of the client and community. Appropriate crisis intervention may result in an overall

improvement in the conditions that created the crisis and eliminate a potential need for psychiatric hospitalization or other restrictive interventions.

Crisis Intervention services are provided by a variety of licensed mental health professionals and trained others in accordance with ODADAS and ODMH provider qualifications. Crisis Intervention services are accessible at each satellite clinic.

Pre-hospitalization Screening involves the assessment of persons in need of psychiatric hospitalization and is a facet of the Emergency Services Program. Pre-hospitalization Screening may be provided to a person of any age who is undergoing a psychiatric crisis. Assessments may occur in a variety of settings, including agency offices, jails, courts, hospitals or natural settings as clinically indicated and deemed appropriate. Objectives are to ensure that least restrictive settings for treatment are considered and appropriately used to provide service to persons undergoing acute exacerbation of psychiatric symptoms and to protect client and societal welfare by referral to public/private psychiatric facilities when necessary.

Only persons who are qualified in accordance with ODMH provider qualification standards provide this service. This service is accessible at each satellite clinic.

AOD OUTPATIENT TREATMENT (INDIVIDUAL COUNSELING, GROUP COUNSELING & INTENSIVE OUTPATIENT)

AOD Outpatient Treatment involves face-to-face interventions with individuals, couples, families and groups. Children and adolescents are eligible for these services and may be seen individually, with family members/guardians/significant others or in groups. Parents/guardians or significant others may also be seen independently as specified in the ISP. AOD Intensive Outpatient Treatment is available for those individuals who require a more intense level of treatment services. Intensive Outpatient services are provided via thrice weekly three-hour groups. The type(s) and modality of substance abuse treatment services are determined by the presenting problem(s) and client needs as are expressed in the ISP. Counseling duration is based on each individual's progress and needs.

Providers of AOD Outpatient Treatment services include person from multiple disciplines, including counselors, social workers, nurses and chemical dependency counselors. All providers meet criteria established in the ODADAS certification standards.

AOD Outpatient Treatment is provided via a process of interaction. Chemically dependent/substance-abusing persons and their family members are eligible for services. Persons who are significantly at-risk for developing chemical dependency are also eligible for treatment services designed to reduce their risk of disease progression.

The Substance Abuse Program strongly encourages that clients develop and maintain quality sobriety. As such, the program is abstinence-based. The Program follows a Stages of Change framework for developing targeted interventions based on each client's stage of change. Motivational interviewing techniques are incorporated into treatment strategies and interventions. The Program uses other quality-of-life indicators to measure treatment success,

including but not limited to changes in family, work, social, psychological and vocational functioning, health status, housing status, academic endeavors, career aspirations, etc.

AOD PREVENTION/DIVERSION

AOD Prevention/Diversion services are designed to delay the onset of first use and to reduce the problematic use of alcohol, tobacco and other drugs (ATOD). These services are designed to enhance protective factors and to remove or reduce risk factors. Substance abuse prevention programming includes life skills training, refusal skills training, social skills training and other evidence-based best practices that are implemented within a developmentally and culturally appropriate framework. The Center's prevention programming is designed to enhance a long-range community-wide effort to provide clear, consistent, repeated, comprehensive messages about healthy living/lifestyle choices.

AOD Prevention/Diversion service strategies include:

1. Information Dissemination – provides awareness and knowledge about the nature and extent of ATOD use, abuse and addiction, their effects on individuals, families and communities and about available prevention programs and services;
2. Education – involves two-way communication between the educator/facilitator and participants and is designed to affect critical life and social skills, including decision making, refusal skills, critical analysis and systematic judgment abilities;
3. Alternatives – provides for the participation of targeted populations in activities that exclude ATOD use;
4. Problem Identification and Referral – identifies those individuals who have indulged in illegal/age-inappropriate alcohol or tobacco use and those who have indulged in the first use of illicit drugs to assess if their behavior can be reversed through education; and
5. Community Based Process- provides for development of a community-wide effort to promote clear, consistent, repeated, comprehensive messages about healthy lifestyle choices.

AOD Prevention/Diversion services are provided in a variety of settings, including agency offices, schools, alternative schools, jails and the participants' natural environments as deemed appropriate. These services are provided by a variety of licensed professionals and trained others in accordance with ODADAS prevention provider qualifications. AOD Prevention/Diversion services are accessible at each satellite clinic.

CURRENT PREVENTION ACTIVITIES BY CLINIC SITE:

Ross County---Martha Cottrill Clinic

1. Education
   - Chillicothe High School Teen Improvement Program
   - Goal: To assist students who have a difficult time in school due to issues with learning in the traditional manner. Students receive one-on-one assistance with their educational studies while also participating in an educational group to deal with any substance abuse issues.

- Target Audience: 11th and 12th grade students who are unable to achieve success in a regular/typical classroom setting.

2. Information and Dissemination
   - Goal: To provide information to the general public and the at-risk public to raise awareness and to offer knowledge of the nature and extent of alcohol, tobacco and other drug use. To offer help/guidance on managing abuse and addictions, their effects on individuals and to provide awareness of available services in place to help at-risk population.
   - Target Audience: All county residents who request information. Public residents that participate at county and local gathering as well are part of this target audience.

Pickaway County Clinic

1. Problem Identification and Referral
   - Goal: To identify individuals who have engaged in illegal substance abuse as well as identification of individuals that have utilized tobacco and/or alcohol before the authorized legal age to do so. The activity also focusses on those that have had a first use of an illicit drug and to determine if education can change behaviors.
   - Target Audience: All age groups

Pike County Clinic

1. Education
   - Weekly prevention education group at Western High/Jr. School
   - Goal: Promote AOD abstinence, build a student-led prevention coalition as well as involve the rest of the school and community in prevention goals by utilizing Project Success curriculum.
   - Target Audience: Western High/Jr. High school students, student families and community
2. Education
   - Too Good For Drugs (Best Practice Curriculum)
   - Goals: learn effective goal setting and healthy choices, step-building for goal completion, decision making skills, bonding with pro-social networks and understanding the importance of healthy relationships, education on appropriate safe and unsafe use of prescribed and over-the-counter medications, identifying and managing emotions and communicating effectively. The group utilizes role-playing, usage of puppets, group work, and meaningful play activities to teach students appropriate methods for handling peer pressure situations.
   - Target Audience: 1st grade students at Eastern Elementary School, 2nd and 3rd grade students at Jasper Elementary School.
3. Education/Information Dissemination
   - After School Program
   - Goal: Promote AOD abstinence, build a student-led prevention coalition and involve the rest of the school and community in preventative efforts. Also participate in student-led prevention rally at the statehouse on 5/2/13 and the members of the

student led prevention coalition presented prevention education to the elementary students during an assembly in the spring.
- Target Audience: All students, families of students and community

4. Alternatives
   - Monthly After School AOD Alternatives Activity
   - Goal: Focus on drug free social skills, community outreach and team building
   - Target Audience: High/Jr. High School Students

Fayette County Clinic

1. Education
   - Classroom and Small Group Discussion Instruction
   - AOD Group at Fayette County Alternative School
   - Goals: To serve students that are currently involved in the court system and/or come from a diverse background by proving group opportunities to speak about the dangers of substance abuse as well as healthy and preventative methods to manage peer pressure. Community leaders are invited and routinely participate in group meetings to help offer guidance and support to group on importance of AOD abstinence.
   - Target Audience: Students who are on probation or diversion and have been deemed unruly, truant, disorderly, etc. and between the ages of 13-18.

Admission Criteria and Discharge Criteria: AOD Prevention/Diversion services are characterized by the population(s) they are designed to impact. Universal prevention services are targeted toward the general population in the Center's five-county service area. Any resident of the Center's service area or any person who is in the Center's service area is eligible to receive this service. Selective prevention services are aimed toward target populations within the general population where risk is greater and may include at-risk children and youth, non-using children of substance-involved parents, children of Metropolitan Housing Authority residents, first time youthful offenders, etc. Indicated prevention services are targeted toward high-risk individuals who may have detectable signs, symptoms or biomarkers for chemical dependency but who are not currently in need of treatment and may include substance-involved adolescents of substance-involved parents, sexually active, substance-using females, etc.

INTEGRATED CARE PROGRAM

In October 2014, the Center began offering primary care service to our clients and community. The goal of the program is to treat the "whole person". Primary care, wellness, behavioral health and substance abuse services are offered in this "one-shop" type of format. Clients are referred to the program at the request of their clinician, or they may call and make an appointment. The general public may make an appointment as well at any time.

CLIENT RIGHTS

1. The right to be treated with consideration and respect for personal dignity, autonomy and privacy; to include freedom from any type or form of abuse, exploitation, retaliation, humiliation and neglect;

2. The right to service in a humane setting that is the least restrictive feasible as defined in the treatment plan;

3. The right to be informed of one's own condition, of proposed or current services, treatment or therapies, and of the alternatives;

4. The right to consent to or refuse any service, treatment, or therapy upon full explanation of the expected consequences of such consent or refusal. A parent or legal guardian may consent to or refuse any service, treatment or therapy on behalf of a minor client; this includes involvement in research projects;

5. The right to a current, written, individualized service plan that addresses one's own mental health, physical health, social and economic needs, and that specifies the provision of appropriate and adequate services, as available, either directly or by referral;

6. The right to be informed how to access self-help and advocacy support services;

7. The right to active and informed participation in the establishment, periodic review, and reassessment of the service plan;

8. The right to freedom from unnecessary or excessive medication;

9. The right to freedom from unnecessary restraint or seclusion;

10. The right to participate in any appropriate and available agency service, regardless of refusal of one or more other services, treatments or therapies, or regardless of relapse from earlier treatment in that or another service, unless there is a valid and specific necessity which precludes and/or requires the client's participation in other services. This necessity shall be explained to the client and written in the client's current service plan;

11. The right to be informed of and refuse any unusual or hazardous treatment procedures.

12. The right to agency adherence to research guidelines and ethics, if applicable;

13. The right to be advised of and refuse observation by techniques such as one-way vision mirrors, tape recorders, televisions, movies or photographs;

14. The right to have the opportunity to consult with independent treatment specialists or legal counsel, at one's own expense;

15. The right to confidentiality of communication and of all personally identifying information within the limitations and requirements for disclosure of various funding and/or certifying sources, state or federal statutes, unless release of information is specifically authorized by the client or parent or legal guardian of a minor client or court-appointed guardian of the person of an adult client in accordance with rule 5122:2-3-11 of the Administrative Code;

16. The right to have access to one's own psychiatric, medical or other treatment records, unless access to particular identified items of information is specifically restricted for that individual client for clear treatment reasons in the client's treatment plan. "Clear treatment reasons" shall be understood to mean only severe emotional damage to the client such that dangerous or self-injurious behavior is an imminent risk. The person restricting the information shall explain to the client and other persons authorized by the client of the factual information about the individual client that necessitates the restriction. The restriction must be renewed at least annually to retain validity. Any person authorized by the client has unrestricted access to all information. Clients shall be informed in writing of agency policies and procedures for viewing or obtaining copies of personal records;

17. The right to be informed in advance of the reason(s) for discontinuance of service provision, and to be involved in planning for the consequences of that event;

18. The right to receive an explanation of the reasons for the denial of services;

19. The right not to be discriminated against in the provision of service on the basis of religion, race, color, creed, sex, national origin, age, lifestyle, physical or mental handicap, and developmental disability;

20. The right to be fully informed of the cost of services;

21. The right to be fully informed of all rights;

22. The right to exercise any and all rights without reprisal in any form including continued and uncompromised access to service;

23. The right to file a grievance; and

24. The right to have oral and written instructions for filing a grievance.

In addition to the above Client Rights, clients of the Floyd Simantel Clinic shall also have the following Resident Rights:

Floyd Simantel Clinic Resident Rights

1. The right to a comfortable, welcoming, stable and supportive living environment in the residential facility;

2. The right to participate in the establishment of, and to have, the least restrictive policies, procedures, or house rules, commensurate with the comfort and safety of all residents;

3. The right to be informed of one's own condition, the reason(s) for recommended residency in the facility, and the available alternatives to such residency;

4. The right to active and informed participation in identification and choice of personal care assistance and mental health services to be provided, as applicable to the type of licensed facility, and in the periodic review and reassessments of such provisions;

5. The right to consent to or refuse residency in the residential facility and/or the provision of any individual personal care activity and/or mental health services;

6. The right to reside in a residential facility, as available and appropriate to the type of care or services that the facility is licensed to provide, regardless of pervious residency, unless there is a valid and specific necessity which precludes such residency. This necessity shall be documented and explained to the prospective resident;

7. The right to reasonable assistance from the facility, or a mental health services provider, that enables and facilitates personal growth and development toward less dependent and less restrictive living environments;

8. The right to freedom from any unusual or hazardous practices or activities;

9. The right to reasonable privacy and freedom from excessive intrusion by visitors, guests, and inspectors;

10. The right to reasonable privacy and freedom to meet with visitors, guests, or inspectors, make and/or receive phone calls, write or receive uncensored, unopened correspondence;

11. The right to confidentiality of written information and communications;

12. The right to have access to all information in facility records about one's self, unless contraindicated and noted in the resident's ISP;

13. The right to receive thirty days prior notice for termination of residency in Type 2 and 3 residential facilities except in an emergency;

14. The right to vacate the facility at any time, except that the responsibility to pay for incurred costs of room and board shall continue unless appropriate notification has been provided to the facility concerning the termination of the residential agreement;

15. The right not to be discriminated against in the provision of any assistance, activity, or service on the basis of religion, race, color, disability, creed, sex, nation origin, age or life-style;

16. The right to written specification of charges, facility and resident obligations and responsibilities;

17. The right to compliance by the facility with all of the requirements for licensure;

18. The right to exercise any and all rights without reprisal in any form, including the right to continued residency. Such rights shall not supersede health and safety considerations, and for Type 1 facilities, the right to refuse mental health services shall not be a condition for denial of continued stay in the facility;

19. The right of access to one's own bedroom or sleeping area at any time, unless contraindicated and noted in the resident's ISP; and

20. The right to file a grievance, appeal, and have due process afforded for an alleged violation of any paragraph of this rule.

IF YOU HAVE ANY COMPLAINT ABOUT SERVICES OR HAVE ANY GRIEVANCE, PLEASE CONTACT THE DIRECTOR OF YOUR LOCAL CLINIC OR ANY STAFF TO REQUEST ASSISTANCE IN ADDRESSING YOUR GRIEVANCE.

Clinic Director
Floyd Simantel Clinic
312 East Second Street
Chillicothe, OH 45601
740/775-1270

Clinic Director
Fayette County Clinic
1300 East Paint Street
Washington C.H., OH 43160
740/335-6935

Clinic Director
Highland County Clinic
108 Erin Court
Hillsboro, OH 45133
937/393-9946

Clinic Director
Martha Cottrill Clinic
4449 State Route 159
Chillicothe, OH 45601
740/775-1260

Clinic Director
Pickaway County Clinic
145 Morris Road
Circleville, OH 43113
740/474-8874

Clinic Director
Pike County Clinic
102 Dawn Lane
Waverly, OH 45690
740/947-7783

Forensic Services Coordinator
Lynn Goff Clinic
134 Jefferson Street
Greenfield, OH 45123
937/981-7701

RESOURCE AGENCIES

ADA - Ohio
700 Morse Rd., Suite 101
Columbus, OH 43214
800-232-6446
800-232-2321 - (TTY)
(614) 844-5410 - (local)
(614) 844-5868 (fax)
www.ada-ohio.org
Email: adaohio@aol.com

Attorney General's Office
Health Care Fraud Unit
150 East Gay Street, 17th Floor
Columbus, OH 43215-9987
(614) 466-0722
(614) 644-9973 (fax)
(614) 466-1393 (TTY)
www.ag.state.oh.us

Client Assistance Program
(For Vocational Rehabilitation)
c/o Ohio Legal Rights Service
50 West Broad Street, Suite 1400
Columbus, OH 43215-5923
(614) 466-7264 or
1-800-282-9181 (Toll free in Ohio only)
TTY: (614) 728-2553 or
1-800-858-3542 (Toll free in Ohio only)
(614) 644-1888 (fax)

Counselor, Social Worker and Marriage & Family Therapist Board
50 West Broad Street, Suite 1075
Columbus, OH 43215-5919
(614) 466-0912
(614) 728-7790 (Fax)
http://www.cswmft.ohio.gov/
Email: cswmft.info@cswb.state.oh.us

CSD of Ohio
4041 North High Street
Columbus, Ohio 43214
Toll Free Voice/TTY: (877) 781-6670
TTY: (614) 889-6914
(614) 889-5815 (voice)
(614) 889-8157 (fax)

Equal Employment Opportunity Commission
Cleveland Field Office
Anthony J. Celebrezze Federal Building
1240 East Ninth Street, Suite 3001
Cleveland, OH 44199
Phone: (800) 669-4000
TTY: 800-669-6820
216-522-7395 (fax)
http://www.eeoc.gov/cleveland/index.html

NAMI Ohio
747 East Broad Street
Columbus, OH 43205
(614) 224-2700
(800) 686-2646
(614) 224-5400 (fax)
Email: amiohio@amiohio.org
www.namiohio.org

State of Ohio Board of Nursing
17 S. High St., Suite 400
Columbus, OH 43215-7410
(614) 466-3947
(614) 466-0388 (fax)
Email: board@nursing.ohio.gov
http://www.nursing.ohio.gov/

Ohio Department of Health
Complaints-Nursing Homes/Health Care Program
246 N. High Street, 2nd Floor
Columbus, OH 43216
1-800-342-0553
(614) 752-6490 (TTY)
(614) 728-9169 (fax)
Email: HCComplaints@odh.ohio.gov
www.odh.state.oh.us

Ohio Department of Jobs & Family Services
30 E. Broad St., 32nd Floor
Columbus, OH 43215
(614) 466-6282
(614) 466-2815 (fax)
(614) 752-3951 (TTY)
www.state.oh.us/odjfs

Ohio Department of Mental Health
30 E. Broad St., 8th Floor
Columbus, OH 43215-3430
Recovery & Rights Advocate: Diane Nutter
Phone: (614) 466-2333
Consumer & Family Toll Free: 1-877-275-6364
1-888-636-4889 (TTY)
(614) 466-1571 (fax)
Email: nutterd@mh.state.oh.us

Ohio Federation for Children's Mental Health, Inc.
1101 Summit Road
Cincinnati, OH 45237
(513) 948-3077
(513) 761-6030 (fax)
OFFCMH@hotmail.com

Ohio Governor's Council on People with Disabilities
400 E. Campus View Blvd.
Columbus, OH 43235-4604
(614) 438-1391 (both voice & TTD)
Toll Free in Ohio (both voice & TTD:
1-800-282-4536 Ext. 1391
(614)438-1274 (fax)
Email: Lucille.Walls@rsc.state.oh.us
http://gepd.ohio.gov/

Ohio Legal Rights Services
8 E. Long Street 5th Floor
Columbus, OH 43266-0523
(614) 466-7264
(800) 282-9181
(614) 644-1888 (fax)
(614) 728-2553 (TTY)
www.olrs.state.oh.us

Ohio Psychiatric Association
1350 W. 5th Ave., Ste. 218
Columbus, OH 43212-2907
(614) 481-7555
(614) 481-7559 (fax)
Email: ohiopsych@ohiopsych.org
http://www.ohiopsych.org/

President's Committee on Employment of People with Disabilities
1331 F Street, NW, Suite 300
Washington, DC 20004
(202) 376-6200
(202) 376-6205 (TTY)
(202) 376-6219 (fax)
Email: info@pcepd.gov
http://www.access4911.org/president's_committee.htm

Office for Civil Rights
U.S. Department of Health and Human Services
233 N. Michigan Avenue, Suite 240
Chicago, IL 60601
Voice Phone: (312) 886-2359
TDD: (312) 886-1807
(312) 886-1807 (fax)

U.S. Department of Medicare
6401 Security Blvd.
Baltimore, MD 21235-6401
(800) 633-4227
(877) 486-2048
www.medicare.gov

Social Security Administration
Office of Public Inquires
Windsor Park Building
6401 Security Blvd.
Baltimore, MD 21235
(800) 772-1213
(800) 325-0778 (TTY)
http://www.socialsecurity.gov

U.S. Equal Employment Opportunity Commission
Cleveland District Office
Anthony J. Celebrezze Federal Building
1240 East Ninth Street, Suite 3001
Cleveland, OH 44199
Phone: (800) 669-4000
TTY: (800) 669-6820
(216) 522-7395 (fax)
http://www.eeoc.gov/cleveland/index.html

Paint Valley ADAMH Board
394 Chestnut Street
Chillicothe, OH 45601
Client Rights Officer: Juni Frey
Phone: (740) 773-2283 ext. 106
(740) 773-2770 (fax)
Email: jfrey@pvadamh.org

Ohio Department of Alcohol and Drug Addiction Services (ODADAS)
280 North High Street, 12th Floor
Columbus, OH 43215
Phone: (614)466-3445
(TDD)(TDY) (614) 644-9140
(614) 752-8645 (fax)
www.odadas.state.oh.us

CLIENT RIGHTS PROCEDURES

1. The Director of each Clinic or Program, as identified above, will serve as a Clients Rights Officer and will be responsible to accept and oversee the process of any grievance filed by a client or anyone on behalf of a client.

2. All workforce members shall be responsible to explain the Client Rights and/or Grievance Procedure upon request.

3. A copy and explanation of the Client Rights shall be given to each person seeking services at the Center. In the case of an emergency, the client should be informed of at least those rights applicable to Emergency Services, such as the right to consent to or refuse treatment and the consequences of accepting or refusing treatment. In an emergency, the distribution and explanation of Client Rights may be delayed until a second contact. Recipients of community services should receive a copy and explanation of Client Rights upon request.

4. A copy of the Client Rights Policy should be posted in a conspicuous location in each facility and is available for review on the Center's website: www.spvmhc.org.

5. Clinic and Program Directors are responsible to assure all workforce members are familiar with the Client Rights and Grievance Procedure.

6. The most current ODMH Client Rights Resource Agencies List is provided to clients as part of this Policy and in the Client Handbook, which is available for review on the Center's website.

GRIEVANCES PROCEDURE FOR EMPLOYEES AND CLIENTS

FOR EMPLOYEES:

1. Employees shall utilize the following process to resolve problems that cannot be resolved otherwise on an informal basis.

2. The Grievance Procedure is designed as an employee tool to seek resolution of' problems which cannot be resolved on an informal basis. The grievance process should be initiated within three (3) weeks of the aggrieved incident.

3. In the initial step of the Grievance Procedure, the employee presents the grievance in writing including dates, persons involved, etc. to their immediate supervisor. A record of supervisory meetings shall be kept by the supervisor and signed by the employee following each stage of the process.

4. The supervisor is required to meet with the employee within five (5) working days of submission of the grievance. If the grievance is not resolved at this level, the employee may request a meeting with the supervisor's supervisor, by submitting the grievance, the written response and a written request for a meeting. This and subsequent meetings should be held

within five (5) working days of the submission of the grievance and may include the employee and other levels of supervisory staff.

5. If the grievance remains unresolved, the employee may submit the grievance, the written response(s) and a written request for a meeting to the appropriate Associate Director: Clinical Services or Finance.

6. If the grievance remains unresolved, the employee may submit the grievance, the written response(s), and a written request for a meeting to the Executive Director, who will meet with the employee within five (5) working days if at all possible.

7. If the grievance remains unresolved, the employee may submit the grievance, the written response(s), and a written request to meet with the Executive Committee of the Board of Trustees at their next regularly scheduled meeting or one called for the specific purpose provided it is sooner than the regular meeting. The Executive Director will facilitate this request. The Executive Committee will make a summary report to the full Board at the next regularly scheduled meeting.
8. The employee, via the Executive Director, may ask the President of the Board of Trustees for a meeting with the Board of Trustees. All Board decisions are to be considered final.

9. Where a grievance goes beyond the level of immediate supervisor and it appears it will not be resolved at the intermediate levels, it may be brought immediately to the appropriate Associate Director so long as the intervening levels of supervision and the employee agree. The administration reserves the right to request that the intermediate levels attempt to resolve the grievance. However, the employee retains the right to appeal to the administration if not satisfied with the action of the intermediate levels of supervision.

FOR CLIENTS:

Any client who has a complaint about Center services, staff or facilities is first encouraged to discuss the grievance with his/her case manager or therapist in an attempt to informally resolve the matter. However, any client who believes his/her rights have been violated is encouraged to follow the steps outlined below.

1. The client should contact the Director of the Clinic or Program where they are being served order to discuss and attempt to resolve the alleged violation. This initial contact can be writing, by phone or in person and the Director is expected to schedule a meeting within five business days to discuss the complaint. The client should be prepared to state how his/her rights have been violated, by whom and when the violation occurred. The client may present the grievance in writing but if unable to do so, the Director will put the complaint in writing for the client (Attachment 1). Any assistance required by the client in filing the grievance shall be provided and the agency will investigate the grievance on behalf of the client and provide representation for the client at the grievance meeting if desired. The Clinic and Program Directors listed shall be responsible to provide any assistance required. The Director

will attempt to resolve the complaint and/or assure the violation is corrected. If the grievance is resolved, all documentation shall be forward to the Administrative Assistant to the Executive Director. If the grievance is unresolved, documentation shall be forwarded to the Associate Director of Clinical Services or the Associate Director of Intensive Services.

2. If the grievance cannot be resolved by the local Clinic or Program Director, the client has the right to request a meeting with the Associate Director of Clinical Services or the Associate Director of Intensive Services, who can be contacted at Scioto Paint Valley Mental Health Center, 4449 State Route 159, P.O. Box 6179, Chillicothe, Ohio 45601-6179 (740/775-1260). The Associate Director of Clinical Services or the Associate Director of Intensive Services will schedule a meeting to attempt to resolve the complaint within five business days. If the grievance is resolved, all documentation shall be forwarded to the Administrative Assistant to the Executive Director. If the grievance is unresolved, all documentation shall be forwarded to the Executive Director.

3. If the grievance remains unresolved, the client may appeal to the Executive Director who can be contacted at Scioto Paint Valley Mental Health Center, 4449 State Route 159, P.O. Box 6179, Chillicothe, Ohio 45601-6179 (740/775-1260). The Executive Director will schedule a meeting with the client to resolve the grievance within five business days but no later than twenty (20) working days from the date the complaint was made. If the grievance is resolved, all documentation shall be forwarded to the Administrative Assistant to the Executive Director. If the grievance is unresolved, all documentation shall be forwarded a committee of the Board of Trustees.

4. If the grievance is not resolved at this level the client may request a meeting with a committee of the Board of Trustees through the Executive Director. A meeting with the committee of the Board will occur within 20 business days or at the next regularly scheduled meeting or one called for the specific purpose of hearing the grievance provided it is sooner than the regular meeting. All Board decisions are considered final. All documents shall be forwarded to the Administrative Assistant to the Executive Director.

5. Minutes of each meeting between the client and staff or Board committee will be kept with both the client and the Center receiving a copy of the meeting minutes.

6. A client or griever may specify any person to receive information about the grievance or to represent him/her in the grievance by written request.

7. All grievances are to be referred directly to the Executive Director when requested by the client if a good faith effort to involve the client in the above process has failed.

8. All clients have the option to initiate a complaint with the Paint Valley Alcohol, Drug Addiction and Mental Health Services (ADAMH) Board, 394 Chestnut Street, Chillicothe, Ohio 45601 (740/773-2283); The Ohio Department of Mental Health, State Office Tower, Suite 1180, 3 East Broad Street, Columbus, Ohio 43215 (614/466-2596); The Ohio Department of Alcohol and Drug Addiction Services, 280 North High Street, 12th Floor, Columbus, Ohio 43215 (1/800/788/7254); The Ohio Legal Rights Service, East Long Street, Columbus, Ohio 43215 (1/800/282-9181); The U.S. Department of Health and Human Services, 606 Central Center, Chillicothe, Ohio 45601 (740/774-5500); or any appropriate professional licensing or regulatory association (See attached Resource Agencies list). Any of the above organizations can receive information about the grievance upon request when a client has initiated a complaint provided the client has signed an Authorization For Release Information with the Center for the organization requesting the information.
9. The Grievance Procedure should be posted in a conspicuous place and should be provided to anyone upon request. All staff shall be responsible for attempting to resolve any and all complaints by clients and to assist clients in the resolution of any complaints with special diligence and attention to those complaints involving a violation of client rights. If the Clinic or Program Director is unavailable or is the subject of the complaint, all staff shall be responsible for assisting the client to contact the Associate Director of Clinical Services or Associate Director of Intensive Services without delay. The Center will not retaliate in any way against a client who files a grievance.