Grant Programs and Service Standards

Alaska Department of Health and Social Services

Division of Behavioral Health

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Section I – Standards Applicable to All Grantees

1. Governance

Regulations & Statues. Grantees are required to meet all regulations and statues that govern Alaska's behavioral health system. While not comprehensive, the following is a list of the perinate behavioral health and substance abuse regulations.

1.1. 7 AAC 70. Behavioral Health Services

1.2. 7 AAC 135. Medicaid Coverage; Behavioral Health Services

1.3. 7 AAC 136. Alaska Substance Use Disorder and Behavioral Health Program: 1115 Demonstration Waiver

1.4. 7 AAC 138. 1115 Substance Use Disorder Waiver Services

1.5. 7 AAC 139. Behavioral Health 1115 Waiver Services

1.6. 7 AAC 160 Medicaid Program; General Provisions

Authority of the Department. The Department of Health and Social Services (DHSS) is granted statutory authority to allow the Division of Behavioral Health (DBH) on-site access to all grantees and access to documents related to grant and Medicaid service delivery (including client files), per AS 47.05 for mental health treatment and AS 47.37 for substance use treatment.

At the request of the department a provider must provide records in accordance with 7 AAC 105.240. The department may review records of Medicaid providers without prior notice from Medicaid providers if the department has cause that is based on reliable evidence to do so, per 7 AAC 160.110 (e).

1.7 **Cultural Competence**. Grantees should strive to meet the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care. At a minimum, grantees are required to provide the following:

1.7.1 Ensure that all staff members provide clients/consumers with equitable, effective, understandable, and respectful care in a manner that is compatible with their cultural health beliefs and practices and is delivered in their preferred language.

1.7.2 Implement strategies to recruit, retain and promote a diverse staff that are representative of the demographic characteristics of the service area at all levels of the organization.

1.7.3 Gender specific treatment and other therapeutic interventions that may address history of trauma, issues of relationships, sexual victimization, sexual identity and parenting.

1.7.4 Ensure that all staff receive ongoing education and training in culturally and linguistically appropriate services and behavioral health equity service delivery. Programs should encompass diversity across the spectrum of minority groups (LGBTQIA+, ethnic and cultural minorities, ESL, etc.).

1.7.5 Offer language assistance to individuals with limited English proficiency and or other communication needs, at no cost to them, to facilitate equity in access to all health care and services.

1.8 **Licensing & Accreditation.** Additionally, grantees must comply with licensing and/or accreditation standards pertaining to necessary safety planning and drills.

1.9 **Benefit Coordination.** Grantees are required to assist clients to access applicable public assistance such as Medicaid.

1.10 **Critical Incident Reporting**. Grantees must comply with the Division of Behavioral Health's critical incident reporting requirements for missing and deceased recipients.

1.10.1 Grantees must submit an incident report within 72 hours based on calendar days to the division. The report template is found on the DBH website.

1.10.2 Grantees must adhere to their accreditation requirements for documenting and responding to critical incidents.

1.11 **Sliding Fee Scale.** Grantees must allow clients to make application for sliding scale fees and/or development of a payment plan.

2. Mental Health Services Block Grant

2.1 **Crisis Response System (CRS)**

2.1.1 **Target Population.** Grantees will make crisis response services available to currently enrolled clients who experience a behavioral health emergency during regular business hours. For non-enrolled individuals, it is expected that the psychiatric emergency services (PES) grantee will provide crisis response services 24/7. However, crisis response services, during regular business hours, will be offered to an individual if the person requests a specific provider, regardless if they are a currently enrolled client and even if the provider is not a PES grantee. Grantees will inform all clients about their crisis response system.

2.1.2 **Face-to-Face Contact.** During office hours and at the provider's place of business, a face-to-face contact with an individual experiencing a psychiatric crisis (homicidal, suicidal, gravely psychiatric disabled) is preferred. The face-to-face crisis intervention may occur in any location that provides reasonable safety for the individual in crisis and the clinician (e.g., clinic office, school). Providers need to prioritize the preservation of safety to protect clients and clinicians, such as using local law enforcement when safety is uncertain or unknown.

2.1.3 **Telehealth or Telephone.** If the behavioral health clinician is not able to meet face-to-face, then telephonic or telehealth services can be provided by the clinician and if possible, in collaboration with an emergency responder or another behavioral health staff member who can be face-to-face with the individual in crisis. An agency may also contract with a crisis-line service, as long as the service is able to meet the standard or connect timely with an on-call employee to resume this function.

2.1.4 **Emergency Department (ED).** If the client (adults and children) requires an assessment in the emergency room or clinic during daytime hours, then the client may be referred to the psychiatric emergency services (PES) grantee responsible for their area. For the Municipality of Anchorage there is no PES grantee. Instead, providers may refer the client to the Providence Psychiatric Emergency Room (PPER), which is a single point of entry for the Municipality of Anchorage. Tribal health beneficiaries may choose to go to the PPER or the Alaska Native Medical Center Emergency Department, where they will be assessed by the emergency response team.

2.1.5 **Immediate Response.** While the provider's immediate response must consider the individual's rights and choices (e.g., to decline services or refuse to take medications), grantees need to make active efforts to prevent a client from decompensating. The provision of an immediate response can be delivered either directly by the provider or through an affiliated resource. Examples include not attending initial appointment post-institutional discharge, not appearing for a medication renewal appointment, losing medications, eviction, and risk of out of home placement.

2.1.6 **Outreach.** Rapid response outreach services should be used, but the grantee must also allow for client choice, to the extent practical in the manner of response and choice of responders.

2.1.7 **Follow-Up Services, Post-Crisis.** Local behavioral health crisis follow-up services shall be provided by appropriate grantee staff (not limited to PES staff) to ensure that the behavioral or psychological concerns associated with the individual's acute distress, impairment, or risk phase have been sufficiently resolved and that the individual no longer presents as an imminent danger to themselves or others or is no longer gravely disabled. This follow-up is intended to ensure stabilization and safety.

3. All Substance Use Disorder Treatment Standards

These programs are intended to serve individuals who present with problematic use of alcohol or other drugs, including prescription and over the counter medications, and household/general use products that can be used as inhalants. Additionally, these programs are intended to include the client's support network in the treatment process, including family members, friends, and/or employers to maximize positive outcomes.

3.1. **Priority Preference.** These programs must give preference to treatment as follows:

3.1.1. Pregnant injecting drug users.

3.1.2. Other pregnant substance users.

3.1.3. Other injecting drug users.

3.1.4. Individuals engaged with Office of Children's Services.

3.1.5. All others.

3.2. **General Requirements SUD.** In addition to the requirements detailed under the specific program service type, grantees are required to meet the general requirements detailed below:

3.2.1. **Co-occurring.** Must provide integrated behavioral health services including delivery of either co-occurring capable or co-occurring enhanced services:

3.2.1.1. **Co-occurring Capable**. These programs incorporate, at every level, the concept that all care is person-centered. Programs may have a primary focus on substance use disorders but are capable of treating clients with sub-threshold or diagnosable and stable mental disorders. Psychiatric services should be available on-site or by consultation, and at least some of the staff should be competent to understand and identify signs and symptoms of acute psychiatric conditions. (ASAM Third Edition)

3.2.1.2. **Co-occurring Enhanced**. These programs routinely (as opposed to occasionally) work with clients that are more acute or associated with more serious disabilities and employ staff who are competent to understand and identify signs and symptoms of acute psychiatric and substance use conditions and can provide concurrent and integrated treatment for both mental health and substance use disorders. (ASAM Third Edition)

3.2.2. **Current Activity Schedule.** Grantees will have a current treatment activity schedule with active treatment hours that are consistent with the program's ASAM Third Edition Level of Care, and the standards as outlined in 7 AAC 70.120.

3.2.3. **Family**. Grantees are required to offer services that help families or the client's support system understand addiction and to support the newly recovering family members or supports. Examples include evening family process groups, education groups, presentations by Al-Anon speakers, etc. Involving key

members of the client's support network in treatment leads to more positive outcomes.

3.2.4. **Waitlist**. Outpatient and residential grantees will establish and maintain a waiting list of persons seeking treatment who cannot be admitted due to space or staffing constraints. Providers must use a unique identifier for injection drug users (IDUs). Individuals who qualify as an IDU requesting treatment must be admitted no later than 14 days after the request. If there is no slot available, then IDUs must be provided with interim services within 48 hours and admitted no later than 120 days after the initial request.

3.2.5. **Interim Services.** Grantees must ensure that clients are provided with harm and risk reduction counseling. To this end, interim services should be provided to individuals on the waitlist and can be provided by the program or another agency. Interim services, which require documentation, should include:

3.2.5.1. Counseling/education about HIV and tuberculosis (TB) that includes risks of needle sharing, transmission to sexual partners and infants, methods of risk avoidance and reduction.

3.2.5.2. Referral for HIV and TB testing and treatment.

3.2.5.3. Counseling on fetal alcohol spectrum disorders (FASD) and fetal drug effects (FDE) for all applicants who are pregnant women.

3.2.6. **Blood-borne Pathogens.** Behavioral health service providers will have staff members trained to provide HIV/AIDS, hepatitis B and C, TB, and FASD education, early intervention, and risk reduction counseling. All clients must receive these services. In addition, grantees must have policies and procedures related to infection control, occupational health and safety, client rights or treatment protocols related to HIV/AIDS, hepatitis B and C, TB, and FASD.

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

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

3.2.9. **Pharmacotherapy for SUD.** Grantees are required to facilitate access to or provide pharmacotherapy for the treatment of substance use disorders. Clients should have a choice as to whether or not they would like to use medications to treat their substance use disorder.

3.2.10. **Medicaid.** If a potential client is not currently a Medicaid recipient, grantees must make every effort to determine their eligibility, by assisting them in completing their enrollment, and to bill Medicaid for qualifying services.

4. Substance Abuse Prevention and Treatment (SAPT) Block Grant Standards

The following are in addition to the SUD standards listed above. Standards that were new or provided more detail requirements are listed, but those that did not vary from others in the manual were not included in this section.

4.1. **45 CFR 96.127 Requirements Regarding Tuberculosis (TB**).

4.1.1. The program must, directly or through arrangements with other public or nonprofit private entities, routinely make available the following TB services to each individual receiving treatment for substance use:

4.1.1.1. Counseling the individual with respect to TB.

4.1.1.2. Testing to determine whether the individual has been infected with mycobacteria TB to determine the appropriate form of treatment for the individual.

4.1.1.3. Appropriate medical evaluation and treatment for individuals infected by mycobacteria TB.

4.1.2. For clients denied admission to the program due to lack of capacity, the program must refer such clients to other providers of TB services.

4.1.3. The program must have infection control procedures to prevent the transmission of TB and that address the following:

4.1.3.1. Screening clients and identifying those individuals who are at high risk of becoming infected.

4.1.3.2. Meeting all state reporting requirements while adhering to federal and state confidentiality requirements, including 42 CFR Part 2.

4.1.3.3. Case management activities to ensure that individuals receive such services.

4.1.4. The program must report all individuals with active TB as required by state law and in accordance with federal and state confidentiality requirements, including 42 CFR Part 2.

4.2. **45 CFR 96.131 Treatment Services for Pregnant Women.** The program must give preference in admission to pregnant women who seek or are referred for, and would benefit from, block grant-funded treatment services.

4.2.1. The program must refer pregnant women to the Division of Behavioral Health when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program.

4.2.2. The program must make interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.

4.2.3. The program must offer interim services as noted in the general SUD standards, plus, when appropriate, counseling pregnant women on the effects of alcohol and other drug use on the fetus and referrals for prenatal care for pregnant women.

4.3. **45 CFR 96.132 Additional Requirements.**

4.3.1. The program must make continuing education in substance use treatment and prevention available to employees who provide the services.

4.3.2. The program must have in effect a system to protect client records from inappropriate disclosure, and the system must:

4.3.2.1. Comply with all applicable state and federal laws and regulations, including 42 CFR Part 2.

4.3.2.2. Include provisions for employee education on confidentiality requirements and the fact that disciplinary action may occur upon inappropriate disclosure.

4.4. **45 CFR 96.135 Restrictions on the Expenditure of the Grant.** The program cannot expend SAPT Block Grant funds to provide inpatient hospital substance use services, except in cases when each of the following conditions is met:

4.4.1. The individual cannot be effectively treated in a community-based, nonhospital, residential program.

4.4.2. The daily rate of payment provided to the hospital for providing the services does not exceed the comparable daily rate provided by a community-based, nonhospital, residential treatment program.

4.4.3. A physician makes a determination that the following conditions have been met:

4.4.3.1. The primary diagnosis of the individual is substance use, and the physician certifies that the individual cannot be safely treated in a community-based, nonhospital, residential treatment program.

4.4.3.2. The service can reasonably be expected to improve the person's condition or level of functioning.

4.4.3.3. The hospital-based substance use program follows national standards of substance use professional practice.

4.4.3.4. The service is provided only to the extent that it is medically necessary (e.g., only for those days that the client cannot be safely treated in a residential, community-based program).

4.4.4. Further, the program cannot expend SAPT Block Grant funds to:

4.4.4.1. Purchase or improve land; purchase, construct, or permanently improve (other than minor remodeling) any building or other facility; or purchase major medical equipment.

4.4.4.2. Satisfy any requirement for the expenditure of non-federal funds as a condition for the receipt of federal funds.

4.4.4.3. Provide financial assistance to any entity other than a public or nonprofit private entity.

4.4.4.4. Make payments to intended recipients of health services.

4.4.4.5. Provide individuals with hypodermic needles or syringes. Provide treatment services in penal or correctional institutions of the state.

4.5. **45 CFR 96.137 Payment Schedule.** The program must ensure that SAPT Block Grant funds for special services for pregnant women and women with dependent children, TB services, and HIV early intervention services are the "payment of last resort", and the program must make every reasonable effort to do the following to pay for these services:

4.5.1. Collect reimbursement for the costs of providing such services to persons entitled to insurance benefits under the Social Security Act, including programs under Title XVIII and Title XIX, any state compensation program, any other public assistance program for medical expenses, any grant program, any private health insurance, or any other benefit program.

4.5.2. Secure from clients or clients' insurer payments for services in accordance with their ability to pay.

4.6. **Audit.** The program shall adhere to the following requirements:

4.6.1. If the program expends $750,000 or more in federal financial assistance during the program's fiscal year, an independent financial and compliance audit must be completed by a certified public accounting firm in accordance with Office of Management and Budget (OMB) Circular A-133. The program must also submit a data collection form and reporting package to the Federal Audit Clearinghouse.

4.6.2. The program may identify the amount of federal financial assistance included in this award or the awarding agency will advise the program of the amount of federal financial assistance included in this award.

4.6.3. If the A-133 audit report includes findings or questioned costs, the program must develop and implement a corrective action plan that addresses the audit findings and recommendations contained therein.

4.6.4. The program must retain records to support expenditures and make those records available for review or audit by appropriate officials of the Substance Use and Mental Health Services Administration (SAMHSA), the awarding agency, the General Accountability Office and/or their representatives.

4.7. **Salary Limitation.** The program cannot use the SAPT Block Grant to pay salaries in excess of Level I of the Federal Senior Executive pay scale.

4.8. **Charitable Choice.** If the program is an SAPT Block Grant-funded program that is part of a faith-based organization, the program may:

4.8.1. Retain the authority over its internal governance.

4.8.2. Retain religious terms in its name.

4.8.3. Select board members on a religious basis.

4.8.4. Include religious references in the mission statements and other governing documents.

4.8.5. Use space in its facilities to offer block grant-funded activities without removing religious art, icons, scriptures, or other symbols.

4.9. If the program is an SAPT Block Grant-funded program that is part of a faith-based organization, the program cannot use SAPT Block Grant funds for inherently religious activities such as the following:

4.9.1. Worship.

4.9.2. Religious instruction.

4.9.3. Proselytization.

The organization must notify potential beneficiaries of the organization's affiliation with a specific religion and any associated religious activities.

4.10. The program may only engage in religious activities if both of the following conditions are met:

4.10.1. The activities are offered separately, in time or location, from block grant-funded activities.

4.10.2. Participation in the activities is voluntary.

4.11. In delivering services, including outreach activities, SAPT Block Grant-funded religious organizations cannot discriminate against current or prospective program participants based on:

4.11.1. Religion.

4.11.2. Religious belief.

4.11.3. Refusal to hold a religious belief.

4.11.4. Refusal to actively participate in a religious practice.

4.12. If an otherwise eligible client objects to the religious character of the program, the program shall refer the client to an alternative provider within a reasonable period of time of the objection.

4.13. If the program is a religious organization, the program must:

4.13.1. Use generally accepted auditing and accounting principles to account for SAPT Block Grant funds similar to other nongovernmental organizations.

4.13.2. Segregate federal funds from non-federal funds.

4.13.3. Subject federal funds to audits by the government.

4.13.4. Apply Charitable Choice requirements to commingled funds when state/local funds are commingled with block grant funds.

4.14. **45 CFR 96.126 Capacity of Treatment for Intravenous Drug Users.** If the program treats injecting drug users, the program must:

4.14.1. Within seven days, notify the state whenever the program has reached 90% of its treatment capacity.

4.14.2. Admit each individual who requests and is in need of treatment for intravenous drug use:

4.14.2.1. Not later than 14 days after making the request, *or*

4.14.2.2. Within 120 days of the request if the program has no capacity to admit the individual, the program makes interim services available within 48 hours, and the program offers the interim services until the individual is admitted to a substance use treatment program.

4.14.3. Offer interim services, when appropriate, that include the standards listed above.

4.14.4. Maintain a waiting list that includes a unique client identifier for each injecting drug user seeking treatment, including clients receiving interim services while awaiting admission.

4.14.5. Maintain a mechanism that enables the program to:

4.14.5.1. Maintain contact with individuals awaiting admission.

4.14.5.2. Consult with the State of Alaska's capacity management system to ensure that waiting list clients are admitted or transferred to an appropriate treatment program within a reasonable geographic area at the earliest possible time.

4.14.6. Take clients awaiting treatment for intravenous substance use off the waiting list only when such persons:

4.14.6.1. Cannot be located for admission into treatment or refuse treatment.

4.14.7. Carry out activities to encourage individuals in need of treatment services for intravenous drug use to undergo such treatment by using scientifically sound outreach models.

4.14.8. Ensure that outreach efforts have procedures for:

4.14.8.1. Selecting, training, and supervising outreach workers.

4.14.8.2. Contacting, communicating, and following up with high-risk substance users, their associates, and neighborhood residents within the constraints of federal and state confidentiality requirements.

4.14.8.3. Promoting awareness among injecting drug users about the relationship between injecting drug use and communicable diseases such as HIV.

4.14.8.4. Recommending steps that can be taken to ensure that HIV transmission does not occur.

4.15. **45 CFR 96.128 Requirements Regarding HIV.** If the program is an SAPT Block Grant-funded HIV early intervention program, the program must make the following services available at the sites at which individuals are undergoing treatment for substance use:

4.15.1. Appropriate HIV/AIDS pre- and post-test counseling that meet the following requirements.

4.15.1.1. Diagnose the extent of the deficiency in the immune system.

4.15.1.2. Provide information on appropriate therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.

4.15.1.3. Therapeutic measures for preventing and treating the deterioration of the immune system and for preventing and treating conditions arising from the disease.

4.15.2. The program must have established linkages with a comprehensive community resource network of related health and social services organizations to ensure a wide-based knowledge of the availability of these services and to facilitate referral.

4.15.3. The program must also ensure that HIV early intervention services are undertaken voluntarily, provided with clients' informed consent, and are not required as a condition of receiving substance use treatment or any other services.

4.16. **45 CFR 96.124 Certain Allocations: Required Services for Programs Receiving Block Grant Funds Set Aside for Pregnant Women and Women with Dependent Children.** If the program receives SAPT Block Grant funds set aside for special services for pregnant women and women with dependent children, including women attempting to regain

custody of their children, the program must provide or arrange for the following:

4.16.1. Primary medical care, including prenatal care, for women who are receiving substance use services.

4.16.2. Childcare while the women are receiving services.

4.16.3. Primary pediatric care for the women's children, including immunizations.

4.16.4. Gender-specific substance use treatment and other therapeutic interventions for women that may address issues of relationships, sexual abuse, physical abuse, and parenting.

4.16.5. Therapeutic interventions for children in custody of women in treatment which may, among other things, address the children's developmental needs and their issues of sexual abuse, physical abuse, and neglect.

4.16.6. Sufficient case management and transportation services to ensure that the women and their children have access to the services provided by (4.16.1) through (4.16.5) above.

4.16.7. The program must also treat the family as a unit and, therefore, admit both women and their children into treatment services, if appropriate.

4.16.8. The program must provide pregnant women, women with dependent children, and their children, either directly or through linkages with community-based organizations, a comprehensive range of services to include:

- 4.16.8.1. Case management to assist in establishing eligibility for public assistance programs provided by federal, state, or local governments.
- 4.16.8.2. Employment and training programs.
- 4.16.8.3. Education and special education programs.
- 4.16.8.4. Drug-free housing for women and their children.
- 4.16.8.5. Prenatal care and other health care services.
- 4.16.8.6. Therapeutic day care for children.
- 4.16.8.7. Head Start.
- 4.16.8.8. Other early childhood programs.

Section II – Specific Program Standards

1. Psychiatric Emergency Services (PES) Program

1.1. **Target Population PES.** Crisis response services are rendered to any resident of the grantee's service area, regardless of ability to pay or whether the resident is presently an enrolled client or a beneficiary, or a non-beneficiary or a person unknown to the grantee.

1.2. **Access PES**. Grantees shall inform service area residents and behavioral health grantees of the availability and manner in which local/regional crisis response services can be accessed (e.g., public service announcements, phone directory, public presentations, hospital info services, brochures).

1.3. **Responsibility PES**. Grantees have a 24/7 responsibility for all residents experiencing a behavioral health emergency in the grantee's service area. While some interventions will inevitably lead to hospitalization, grantees are encouraged to stabilize clients locally and referrals to local programs and services are preferred. In many instances, there is less disruption to a client's life if he/she can be supervised in a safe place close to home with services by a local behavioral health agency. Grantees are responsible for keeping the division updated on changes to locations served and crisis response manager(s)/staff names and contact information.

1.4. **Staff PES**. The grantee shall ensure that a master's level clinician, as defined in 7 AAC 70.990(28), is available 24/7 to respond to emergencies.

1.4.1. **On-call Clinician**. The on-call clinician must be available by phone and face-to-face for support to this process.

1.4.2. **Use of Associated Community/Village Persons Standard.** Grantees may use local health/behavioral health aides to assist when the grantee's office is located more than 50 miles from the client in crisis or is not on the state road system. The on-call clinician may assist local health/behavioral health aides or other reliable persons to assist village public safety officers (VPSOs) or village safety officers (VSOs) to screen and assess clients for emergency detention. The VPSO/VSO may file the MC-105 form, titled "Notice of Emergency Detention and Application for Evaluation."

1.5. **Services PES**. The psychiatric emergency services provided by the grantee include a 24/7 crisis line, crisis intervention, clinical screening and assessment, and crisis stabilization.

1.5.1. **Crisis-line.** Behavioral health emergency phone calls are the responsibility of the grantee; however, these required crisis line services may be covered by a clinical associate or provided by an affiliated service (e.g., the grantee's after- hours answering service; a community- or service area-wide crisis hotline; a phone in a

local emergency room), so long as that service has the ability to immediately contact the grantees' on-call clinician when informed of a behavioral health emergency.

1.5.2. **Emergency Appointment/Contact Response Time**. A behavioral health clinician informed of an emergent matter must respond (face-to-face or by phone) to the request for emergency evaluation or intervention services within two hours of contact by the crisis line responder. When necessary, grantees may delay the evaluation until an individual's intoxication level will allow participation in the assessment process.

1.5.3. **Screening and Assessment.** Screening and assessment services are provided when a person in crisis presents with suicidal or homicidal ideation or is gravely psychologically disabled and likely to need hospitalization.

1.6. **Involuntary Commitment** (AS 47.30.700-795)

1.6.1. **MOA with the Nearest Local or Regional Hospital** (7 AAC 72.110 Written agreements). The grantee will develop a written memorandum of agreement (MOA) with the Alaska Psychiatric Institute (API) and the designated evaluation treatment (DET) facilities at Bartlett Regional Hospital (BRH) and Fairbanks Memorial Hospital. For Southeast, an MOA is required with the designated evaluation and stabilization (DES) facility in Ketchikan at PeaceHealth Medical Center. The grantee will develop an MOA with any hospital or clinic within 50 miles of the grantee's main office, in addition to the DES or DET facilities.

1.6.1.1. The MOA will describe grantee and hospitals' responsibilities when responding to a local or service area behavioral health crises, including the option for shared emergency on-call services, so long as there is 24/7 community service area coverage.

1.6.1.2. Where appropriate and applicable, the agreement will also describe the process for a hospital's credentialing of a grantee's mental health professionals and masters-level clinicians, so that behavioral health clinical staff are able to provide face-to-face client screenings and assessments in the hospital's emergency department or acute care treatment unit, especially for other than DET hospitals.

1.6.1.3. As a part of this agreement, after being notified by the facility of a client's discharge, the grantee will schedule an appointment for that individual at their agency to occur within seven calendar days of the client's discharge. The grantee will make every effort to provide medication management services, including a psychiatric evaluation, as soon after discharge from the hospital as possible, assuming that the client has agreed to this discharge plan and is interested in follow-up care from the identified grantee.

1.6.2. **MOA with Law Enforcement**. The grantee will develop written agreements with local and service area law enforcement agencies for the handling of psychiatric emergencies. This will include protocols for grantee mental health professionals and master's level clinicians to provide face-to-face screening and assessment at jails,

juvenile detention facilities (if located within 50 miles of the grantee's clinic), and local hospitals. Screening and assessment shall include petitioning for commitment orders, if necessary, and regular re-assessments of persons in crisis being held for transport.

1.6.3. **Knowledge of Commitment Procedures**. Whenever necessary, a grantee's clinician petitions for involuntary commitment orders and arranges for secure transportation of the person in crisis to the evaluation or treatment services at a designated evaluation and stabilization or designated evaluation and treatment facility.

1.6.4. **Court Request for Community Behavioral Health Assessment.** The court in evaluating a petition, can request the assistance of a community behavioral health provider to perform an assessment. The provider is not expected to find a missing person or put themselves into any type of unsafe situation.

1.6.5. **Re-Assessment every 24 hours.** PES grantees are required to conduct re-assessments no less than once every 24 hours for any person being held for transport to an evaluation facility. If the agency incurs special circumstances that create challenges to meeting this standard, then they may apply for an alternative agreement from the division.

1.6.6. **Department of Corrections (DOC)**. If the client is incarcerated and pending release from DOC custody and the DOC determines that the individual requires a Title 47 assessment, then the PES grantee will go into the jail to perform the assessment. Except for clients pending release from the Anchorage Correctional Complex (ACC), where the DOC mental health clinicians will perform the Title 47 assessment.

1.6.7. **Prior to Transport to DES/DET or API.** To the extent that the PES grantee is able, the receiving hospital will be made aware of the client's prior or current provider and relevant social services for discharge planning and continuity of care.

1.7. **Post-Hospitalization Follow-Up Standard PES.** Continuity of care requires that persons discharged from psychiatric hospitalizations should be connected or re- connected to after-care services through their local grantee as quickly as possible.

1.7.1. **Scheduling a Follow-up Appointment.** A grantee shall accommodate all requests for post-hospitalization follow-up appointments from API, North Star, and other hospitals, including DES or DET hospitals' social workers. The grantee will ensure that such appointments are scheduled to occur at its clinic within seven calendar days of the client's date of discharge, and will, if possible, provide the discharging hospital's social worker with the name of the clinician with whom the discharged client's intake or counseling session is scheduled. Whenever possible, this information is to be included on the client's discharge papers, so that the client has access to their follow-up information after leaving the hospital.

1.7.2. **Documentation of the Follow-up Appointment.** It is the intent of this criterion that every hospitalized psychiatric client will see a grantee clinician within no more than seven calendar days of their date of discharge from the hospital. To this end, the grantee will make every attempt to telephonically reconfirm any grantee

appointment made for a person while they were hospitalized and encourage that person's on-time appearance for their scheduled grantee intake (if a new client) or follow-up counseling session (if a current client).

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

2.1. **Target Population SED.** An infant, child, or youth under 21 years old qualifies as experiencing a severe emotional disturbance (SED) by meeting the definition in 7 AAC 70.930.

2.2. **Access.** Grantees funded to serve children and youth with serious emotional disturbances should prioritize access to treatment for existing or returning clients or clients who are at imminent risk of moving to a higher level of care.

2.2.1. **Referral.** When grantees are unable to provide treatment to youth and families, they must assist in identifying alternative services or providers. The agency should ensure that the client/ client's family or advocate understands how to access alternative services or follow through with a referral.

2.2.2. **Prioritization Response.** Grantees funded to provide treatment to children and youth with serious emotional disturbances must provide an immediate response, either directly or through affiliated resources, to situations in which an existing client is likely to become destabilized and require more restrictive residential or hospital-based care or if it appears that the support system, family, or caretaker is not following through with the youth's treatment plan. Examples include referrals to housing resources, following through with a phone call or offer to provide transportation (ISP funding) for missed groups or medication appointments, or contacting OCS with a report of harm if youth is placed at risk through failure to follow with medication or misuse of medication.

2.3. **System of Care SED.**
Collaboration. SED youth grantees should demonstrate an ongoing effort to create collaborative relationships with other youth-serving agencies and seek to maximize the use of community resources to enhance the services/system of care in a region or community. Local agencies to partner with may include the following: Division of Juvenile Justice, Office of Children's Services, informal supports, childcare, medical providers, Tribal entities, peer support and parent advocates.

2.3.1. **Child, Youth and Family Focused and Guided Services.** Families are our first line of intervention. Services should be guided by the child or youth and the family's needs and wishes. Family needs that impact the child's behavioral health should be met by the grantee or through highly collaborative relationships with other agencies. Family can include biological family members, relative placement, fictive kin, and/or foster family.

2.3.2. **Family Assessment.** If family members are suspected to have behavioral health needs, providers should offer or coordinate access to screening, assessment and treatment or refer the family member to another provider. Providers should coordinate services to the fullest extent possible and in a manner that respects each family member's wishes regarding confidentiality.

2.3.3. **In-home Supports.** Whenever appropriate, treatment should include in-home family services, which may be delivered by the behavioral health service provider or a partner provider.

2.3.4. **Children Birth to Five and their Families.** SED grantees serving young children must:

2.3.4.1. Possess the skills necessary to screen, assess and treat young children with their families, including use of the DC: 0–5 (Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood) and appropriate training in early childhood best practice interventions.

2.3.4.2. Develop linkages and service partnerships to keep young children in their preschools, childcare, Head Start/pre-K and home settings, including referral for early, periodic, screening, diagnostic and treatment (EPSDT) services, infant learning, or Head Start.

2.3.4.3. Facilitate transition planning for children transitioning from early childhood mental health services to other service providers.

2.3.5. **Services for Youth and Young Adults of Transition Age (16 to 24).** Grantees must work to develop the skills, services, and partners necessary to engage transition age youth with the necessary behavioral health, recovery and life domain supports to successfully transition to adult independence or to adult services.

2.3.5.1. **Eligibility for Youth Services:** If indicated, transition age youth (TAY) may continue to receive services in the service system for youth with serious emotional disturbances until age 21.

2.3.5.2. **Transition Age Youth and Young Adult Engagement.** Grantees are expected to use evidence-supported practices to engage youth. The Transition to Independence Process (TIP) model is one such practice and is supported by DBH.

2.3.5.3. **TAY Transition Planning.** The treatment planning process must include the TAY and any individuals identified by the youth.

2.3.5.4. **TAY Services.** TAY treatment plans must include necessary services across life domains (peer supports, housing supports, education/work supports, skill training for independent living, other natural supports, and

community resources) and grantees must work towards providing or linking TAY with these services.

2.3.5.5. **Transition to Adult Services or Discharge.** Treatment plans must incorporate the transition into adult treatment and rehabilitation services, or a plan for discharge from services. If the adult system does not provide the same level of intensive services that a TAY has been receiving, or if the plan is to discharge the TAY from treatment, the transition plan must include provisions to "step down" the service level over time.

2.3.6. **Post Hospital or Institution Services.** Grantees must have written policies and procedures that provide for timely review to consider acceptance of a child or youth client with a serious emotional disturbance who is returning to treatment after being discharged from a hospital, juvenile justice facility, residential treatment, or other institution.

2.3.6.1. **Psychiatric & Clinical Services.** For medication continuity, an evaluation by a medical prescriber should occur before release/discharge medications have run out. Policies and procedures must include the provision of follow-up clinical and psychiatric services to clients currently enrolled with the grantee organization, or who were enrolled with the grantee organization prior to the hospital, juvenile justice, residential treatment, or other institutional episode.

2.3.6.2. **Engagement.** For clients who do not attend a first appointment, attempts to engage these individuals in treatment must be made and documented.

2.3.6.3. **Assessment.** Initial assessments post-discharge/release should be scheduled to occur within seven calendar days.

2.3.6.4. **Placement.** For clients who do not yet have an established place to live, the grantee must have procedures in place to assist the institution with discharge planning and coordination, including assisting with the location of an appropriate living situation.

3. Children's Residential Treatment Services for Youth with Serious Emotional Disturbance (SED Residential)

3.1. **Target Population Children's Residential Treatment Services.** Youth under 18 years old who meet the criteria for serious emotional disturbance (7 AAC 70.930) and require out-of-home therapeutic placement qualify for Residential Behavioral Rehabilitation Services (BRS). Note: serving youth 18 and over in a youth residential care facility requires a variance from the Division of Health Care Services' Health Facilities Licensing and Certification.

3.2. **Access Residential Behavioral Rehabilitation Services.** Except for an emergency placement or crisis stabilization, all youth must have a behavioral health assessment that meets 7 AAC 135.110. It must be completed at the time of admission or use an assessment that has been completed within the past 90 days and must indicate the youth meets criteria for being severely emotionally disturbed (SED). The symptoms and impairments must be the result of a mental health or co-occurring substance use diagnosis.

3.3. **System of Care Residential Behavioral Rehabilitation Services.** Residential care is therapeutic, rehabilitative, and supportive services provided in a community-based residential setting. Providers are required to include the child or youth's family in all aspects of treatment unless contraindicated. There are four types of residential treatment programs: therapeutic treatment home, emergency stabilization and assessment centers, residential treatment, and residential diagnostic treatment (RDT).

3.3.1. **Therapeutic Treatment Home.** These services provide treatment and support in a home-like setting by specially trained foster parents. These homes have a maximum of five beds for children or youth, and grantees provide 24-hour emergency support. Services include case coordination with family members, Office of Children's Services, Division of Juvenile Justice, community providers (schools, community mental health, physicians, and others), highly individualized treatment plans and rehabilitation service. All involved agencies should collaborate to create comprehensive treatment plans that reduce the need for multiple treatment plan objectives and interventions. Treatment plans should address home, school, and community functioning. Funds allocated to these programs may be used to locate and train foster parents.

3.3.2. **Emergency Stabilization and Assessment Centers (Shelters).** These centers provide interim services for youth with behavioral problems that cannot be safely or effectively managed in their present environment, who need short-term, temporary placement, or require stabilization, an assessment of their needs, and appropriate referrals.

3.3.3. **Residential Treatment.** These programs provide treatment services in a 24-hour staffed setting. The purpose of residential care services is to work with youth and/or family to remediate specific problem behaviors that have been explicitly identified in the assessment and treatment plan. These services are provided to children to treat debilitating psychosocial, emotional, and behavioral disorders in a safe and structured setting. Residential treatment provides a therapeutic environment for children/youth that are unable to be treated effectively in their own family home, or a foster home with the goal of being able to manage their own behaviors in their home, school, or community settings.

3.3.4. **Residential Diagnostic Treatment (RDT).** These programs provide specialized treatment services for a subset of youth who present with a specific problem (e.g., sexual offending, trauma victims). The RDT is designed to provide comprehensive

mental health and behavioral services to youth who exhibit more serious and destructive behaviors, have been identified as having more intensive needs, or need a more structured setting with psychiatric service available. These programs typically have higher clinician-to-client ratios. They may be at higher risk of an out-of-state placement.

3.4. **Responsibility of BRS Facilities/Homes.** Grantees are responsible for abiding by additional regulations and statues that work in conjunction with behavioral health services to provide safe and effective treatment for children.

3.4.1. **Residential Child Care Facility (RCCF) and Therapeutic Foster Care Licensing (TFC), Therapeutic Treatment Home.** Grantees are required to maintain RCCF or foster care license through the Division of Health Care Services' Residential Licensing Section (7 AAC 50.005-7 AAC 50.990) and/or as a licensed child care placement organization to provide therapeutic treatment.

3.4.1.1. **Restraint and Seclusion.** All grantees must meet the restraint and seclusion requirements in 42 CFR 483.350-483.376.

3.4.1.2. **Missing, Seriously Injured or Deceased Clients.** Grantees providing residential services must comply with the requirement to notify the Division of Behavioral Health of any instances in which a client is found to be missing, seriously injured or deceased. This requirement applies to any facility operated by the agency or closely affiliated with the agency, including facilities with on-site staff, assisted living homes, supported living homes, residential treatment, therapeutic treatment homes and crisis respite facilities.

3.4.1.3. **Discharge from BRS.** Discharge plans should include plans to return home, as well as alternative placements when indicated. Community providers and services should be identified at the time of admission to a BRS program. Transition planning should be coordinated with the identified agencies. Discharge should occur when it is no long medically necessary for the child to remain at a higher level of care.

4. Outpatient Treatment for Adults with Serious Mental Illness (SMI Outpatient)

4.1. **Target Population SMI.** An adult 21 years or older qualifies as seriously mentally ill (SMI) by meeting definition in 7 AAC 70.920. Individuals 18-21 years old can be served under this program type if they, except for age, fall within the definition of an adult experiencing a serious mental illness.

4.2. **Access.** Grantees funded to provide treatment to adults with serious mental illness must facilitate access to treatment.

4.2.1. **Referral.** When grantees are unable to provide treatment to an adult client they must, to the best of their ability, facilitate useful referrals. Useful referrals require that the organization referred to be accepting referrals, that the organization generally serve the type of client who is being referred, and that the client or client's advocate/case worker understands how to follow through with the referral.

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

4.2.3. **Post Hospital or Institution Services.** Grantees must have written policies and procedures in place to allow the immediate acceptance of an enrolled or newly referred adult client with a serious mental illness into treatment who is being released from a hospital, jail, or other institution. These policies and procedures will include the provision of follow-up clinical and psychiatric services to clients currently enrolled with the grantee organization, or who were enrolled with the grantee organization prior to the hospital, jail, or other institutional episode.

4.2.3.1. **Clinical.** Initial assessments post-discharge/release should be scheduled to occur within seven calendar days.

4.2.3.2. **Psychiatric.** For medication continuity, an evaluation by a medical prescriber should occur before release/discharge medications have run out.

4.2.3.3. **Engagement.** For clients who do not attend a first appointment, attempts to engage these individuals in treatment must be made and documented.

4.2.3.4. **Placement.** For clients who do not yet have an established place to live, the grantee must have procedures in place to work with the institution on discharge or release planning and coordination, including assisting with the location of an appropriate living situation to the best of their ability.

4.3. **Continuum of Care SMI.** Services for adults with serious mental illnesses occur on a continuum of care, ranging from outpatient clinic-based services to community-based supportive services.

4.3.1. **Client Engagement.** Grantees must document efforts to re-engage individuals who have missed appointments or dropped out of treatment.

4.3.2. **Support Services.** Support services (e.g., benefit application, housing, employment, and peer support services), as appropriate, should began shortly after assessment.

4.3.3. **Specialized Treatment.** Specialized treatment should be provided for SMI adults who have behaviors that fall into one or more of the following categories: sexually inappropriate/sexual offending, arson, fetal alcohol spectrum disorder (FASD), traumatic brain injury (TBI), Alzheimer's, intellectual difficulties, or pervasive developmental disorder in their childhood. If the agency does not have this expertise and the client has been assessed as needing specialized treatment, then referrals should be made, or consultation secured for these cases.

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

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

4.4. **PASRR - Preadmission Screening and Resident Review Program.** This state program, required by federal law, provides screening to determine whether placement in a skilled nursing facility is appropriate when the individual has a serious mental illness.

4.4.1. **Preadmission Screening and Resident Review Program.** Grantees providing services to this population must respond to a DBH request for a Level II assessment under the Preadmission Screening and Resident Review Program (PASRR).

4.4.2. **Forms.** Grantees must use the assessment form provided by DBH and may also bill the division for this service.

4.4.3. **Seven Day Turnaround.** Completed evaluations must be returned to the division within seven calendar days of the request.

5. Peer and Consumer Support Services (Peers)

5.1. **Target Population Peers.** The persons who would benefit from these services are children experiencing a severe emotional disturbance (SED), adults experiencing serious mental

illness (SMI), children or adults experiencing substance use disorder (SUD), and children or adults experiencing SUD and co-occurring SMI, plus, family members of individuals included in the pre-listed target population.

5.2. **Access Peers.** Grantees that provide peer and consumer support services must facilitate access to treatment, recovery supports and community-based services (e.g., housing and employment and mutual support self-help programs for families and individuals).

5.2.1. **Outreach.** Grantees that provide peer and consumer support services will outreach to individuals and/or families in one or more of a variety of settings including, but not limited to, emergency departments, homeless camps and shelters, inpatient settings, crisis stabilization programs, intensive day programs, drop-in centers, recovery residences, assisted living homes and/or family service and support programs.

5.2.2. **Transition Supports.** Some peer and consumer support programs will provide transition supports from institutions, residential treatment, hospitals, crisis respite or intensive day programs into community recovery services and supports. Transition supports will include group and individual introduction to recovery principles in the high intensity environment, individual relationship building while in the high intensity environment, and follow-up supports in the community to include a warm handoff into other recovery supports and services.

5.2.3. **Responsibility Peers.** Peer and consumer support services can be provided in peer- and consumer-operated organizations, community-based organizations not operated by peers or consumers, community mental health centers and substance use treatment centers.

5.2.3.1. **Peer- and Consumer-Operated Organizations.** Peer- and consumer-operated organizations are owned, administratively controlled, and operated by people experiencing mental health or substance use recovery or family members and emphasize self-help as their operational approach. Grantees in this category of service will incorporate implementation and practice principles from SAMHSA's Consumer-Operated Services Evidence-Based Practices (EBP) KIT into their operations. Examples of peer-operated organizations include drop-in centers, recovery residences, and psychosocial clubhouses. Not all of these types of organizations are peer-operated, but many are if they have a majority of peers/consumers on the board of directors, involve membership in decision-making and have a majority of paid staff who identify as peers and/or family members.

5.2.3.2. **Community-Based Organizations, Non-Peer or Consumer-Operated.** These are organizations that provide a variety of community services for individuals and family members with SMI, SUD and/or co- occurring disorders that hire individuals who are qualified to provide consumer and

peer support services. Organizations in this category are recovery- oriented but do not necessarily provide treatment. They do, however, hire peer practitioners who provide peer support services. Grantees that hire peers as providers must incorporate recovery principles into their service provision and they must ensure that peer and consumer support practitioners are qualified to provide the services. Peer and consumer support practitioners in these settings will be incorporated into the service array with recognition of their distinct and important role in facilitating recovery. In addition, non-peer-operated community organizations that offer peer support must ensure that supervision of peer and consumer support staff members is consistent with recommended current best practice and state Medicaid regulations for peer support, if applicable. Examples of programs that provide peer support services that are not peer- and consumer-operated include, but are not limited to, residential treatment, recovery residences, emergency departments, family support programs, housing programs and employment programs.

5.2.3.3. **Community Mental Health Centers and Substance Use Treatment Centers.** Grantees under this category hire peer and consumer support specialists to be integrated into a treatment team with a distinct and important role that facilitates recovery. Grantees must incorporate recovery principles into their service provision and must ensure that peer and consumer support practitioners are qualified to provide the services. In addition, grantees will ensure that supervision is provided in accordance with current best practice and compliant with Medicaid regulations for peer support, if applicable.

5.2.4. **Staff.** Organizations providing peer and consumer support services recognize the importance of developing a workforce of qualified peer and consumer practitioners and qualified peer and consumer support supervisors. Organizations will use the 12 categories of core competencies identified by SAMHSA in hiring, training and credentialing both peer support practitioners and their supervisors. The SAMHSA Core Competencies are founded in the following five principles:

5.2.4.1. Recovery-Oriented

5.2.4.2. Person-Centered

5.2.4.3. Voluntary

5.2.4.4. Relationship-Focused

5.2.4.5. Trauma-Informed

5.2.5. **Peer and Consumer Support Staff.** By sharing their experiences, peers bring hope to people in recovery and promote a sense of belonging within the community. A peer or consumer support staff is someone qualified to work as a practitioner by nature of having personal "lived" experience with behavioral health recovery and/or treatment that they are willing to self-disclose with others, or a family member of an individual who has personal "lived" experience and has work experience and/or training specific to the job of peer and consumer support specialist. Family members are most appropriate to be peers with family members. Individuals with substance recovery are most appropriate to be peers with people in substance recovery and people with mental health recovery are most appropriate to be peers with people with mental health experiences.

5.2.6. **Peer Support Practitioner Supervisors.** Supervisors of peer and consumer support staff will be qualified to supervise based on having worked as a peer support practitioner and having demonstrated supervisory competencies or if they have not worked as peer/consumer practitioner that they have demonstrated knowledge of recovery and peer and consumer support through work experience and/or training. Organizations are cautioned to ensure that if they are billing Medicaid for peer support services that the supervisor be a qualified mental health clinician as per regulation. Models of co-supervision (sharing between qualified mental health clinician and experienced peer support practitioner) are acceptable.

5.3. **Continuum of Care Peers.** Build community by helping peers make new friends and build healthy social networks through emotional, instrumental, informational and affiliation types of peer support. Peer and consumer supports are provided within a continuum of care ranging from inpatient and residential treatment to outpatient treatment and clinic services and community-based recovery services such as employment and housing. Peer and consumer supports must include one or more of the following:

5.3.1. Peer mentoring or coaching: Developing a one-on-one relationship in which a peer leader with recovery experience encourages, motivates, teaches, and supports a peer in recovery.

5.3.2. Peer recovery resource connecting: Connecting the peer with professional and nonprofessional services and resources available in the community.

5.3.3. Recovery group facilitation: Facilitating or leading recovery-oriented group activities, including support groups, skill building and other educational activities.

5.3.4. Building community: Helping peers make new friends and build healthy social networks through emotional, instrumental, informational and affiliation types of peer support.

5.3.5. Peer and Consumer Supports may also include: Facilitating development of a recovery culture, system advocacy, peer supervision and educating public and policymakers.

5.4. **Coordination of Care for Peers.** Peer and consumer support services that do not provide a full range of treatment and recovery services will provide a warm handoff to other providers.

6. Supported Housing

6.1. **Target Population.** An adult experiencing a serious mental illness who is 18 years of age or older who falls within the definition of an adult experiencing a serious mental illness (SMI), as defined in 7 AAC 70.920, or as having a substance use disorder and due to their level of impairment requires services in community-based housing.

6.2. **Access to Supportive Housing.** Grantees must have policies and procedures in place that define the selection process by which adults who meet the criterion for the target population are chosen for participation in the housing program.

6.3. **Range of Supportive Housing.** Supportive housing can range on a continuum of care. Some service models have additional program standards to which they need to comply, as referenced in the original request for proposal or the signed grant agreement.

6.3.1. Recovery residences are non-medical settings designed to support recovery from substance use disorders. They provide a substance-free living environment commonly used to help individuals transition from highly structured residential treatment programs back into their day-to-day lives.

7. Permanent Supported Housing (PSH)

7.1. **Target Population Permanent Housing.** An adult experiencing a serious mental illness who is 18 years of age or older who, except for age, falls within the definition of an adult experiencing a serious mental illness (SMI), as defined in 7 AAC 70.920, or as having a substance use disorder and due to their level of impairment requires services in community-based housing that provides behavioral health services based upon the recipient's needs.

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

Projects for Assistance in Transition from Homelessness (PATH) must meet eligibility as defined by SAMHSA and authorized by the Stewart B. McKinney Homeless Assistance Amendments Act of 1990.

7.1.1. **Access Permanent Housing.** Grantee will provide access to housing to include, at minimum: a) full access to housing with no required demonstration of housing readiness, and b) individual privacy in housing units.

7.2. **Continuum of Care Permanent Housing.** Permanent supportive housing (PSH) is an evidence-based practice characterized by the availability of recovery-oriented services in integrated community settings coupled with safe and affordable housing to promote recovery and self-sufficiency for individuals served by these programs.

7.2.1. **Range of Supportive Housing.** Supportive housing can range on a continuum of care. Some service models have additional program standards to which they need to comply, as referenced in the original request for proposal or the signed grant agreement.

7.2.1.1. **Low Intensity Community-Based Services** (i.e., standard mental health outpatient and/or standard substance use disorder outpatient treatment, including PATH grants). PATH teams must comply with all SAMHSA requirements outlined in the Funding Opportunity Announcement and the State of Alaska's RFP.

7.3. **Operational Practices.** Requirements of grantees operating permanent supportive housing programs:

7.3.1. **Enrollment.** Grantees funded to provide permanent supportive housing services must formally enroll an individual into their services as soon as they begin working with the individual, even if the only service the individual is initially requesting is housing services. Formal enrollment includes screening, assessment, initial treatment plan and enrollment into AKAIMS.

7.3.2. **Care Coordination/Warm Handoff.** Grantees must provide individuals with access to all services for adults with behavioral health diagnoses as is appropriate to their diagnoses and functional capacity. Some services may be provided by another behavioral health grantee or other provider type with which the grantee has memorandum of understanding.

7.3.3. **Assessment.** Have basic training and an understanding of the DSM 5 and the ASAM Third Edition.

7.3.4. **SAMHSA Fidelity Scale.** Adhere to SAMHSA's Fidelity Scale for Permanent Supportive Housing. The following are practices, based on the Fidelity Scale, which

DBH requires to meet the needs of individuals receiving permanent supportive housing.

7.3.4.1. **Choice.** Provide a choice of housing to include, at a minimum: consideration of an individual's preference of type of housing; level of community integration; and choice regarding living arrangements, particularly regarding roommates and any shared space.

7.3.4.2. **Separation of Services.** Provide separation of housing and services to include, at a minimum: a functional separation between housing management and services staff.

7.3.4.3. **Affordable Housing.** Grantee will provide access to decent, safe, and affordable housing options to include, at a minimum: individuals paying 30% or less of their income for rent; and housing in compliance with HUD Housing Quality Standards.

7.3.4.4. **Community Integration.** Grantee will provide housing integration to include, at a minimum: individuals living in housing units typical of the community; without clustering people with disabilities.

7.3.4.5. **Rights of Tenancy.** Grantee will provide rights of tenancy to include, at a minimum: individuals having full rights of tenancy; and tenancy not contingent in any way on compliance with program or treatment participation.

7.3.4.6. **Services.** Grantee will provide flexible and voluntary services to include, at a minimum: individuals being offered a full range of services; choice of services with the ability to make changes to those services; choice of service providers as preferences change; and services that are recovery-orientated and consumer-driven.

8. Supported Employment and Supported Education

8.1. **Target Population Supported Employment.** An adult experiencing a serious mental illness who is 18 years of age or older who, except for age, falls within the definition of an adult experiencing a serious mental illness (SMI), as defined in 7 AAC 70.920, or as having a substance use disorder and due to their level of impairment requires services in community based housing that provides behavioral health services based upon the recipient's needs.

In some instances, the treatment team may decide that an SED youth between the ages of 16 and 21 would best be served in supported employment or education services for adults with a serious mental illness. This may be due to the unique characteristics of the youth. This should be documented in the clinical record.

8.2. **Access Supported Employment.** Grantee will provide access to supported employment at a minimum to include: A) full access to employment services with no required demonstration of employment readiness; and B) the focus will be on competitive employment.

8.3. **Continuum of Care Supported Employment.** Supported employment helps individuals with SMI and/or SUD participate in the competitive labor market. It helps them find meaningful jobs and provides ongoing support from a team of professionals. Supported employment occurs within the most integrated and competitive settings that provide individuals with SMI and/or SUD opportunities to live, work and receive services in the community. Outreach and engagement should be provided to individuals who haven't expressed interest in employment but could benefit from it.

8.4. **Supported Employment Models.** Grantees must choose from the identified models as stated in their grant agreement and authorized by the Division of Behavioral Health.

8.4.1. **Individual Placement and Support (IPS) Model** is an evidence-based practice that is designed to assist persons with SMI and/or SUD obtain employment in a competitive environment using the supports of their treatment team and an employment specialist. The IPS model is based on eight practice principles: competitive employment, systematic job development, rapid job search, integrated services, benefits planning, zero exclusion, time-unlimited supports, and worker preferences. The IPS model adheres to a 25-item fidelity scale. The IPS programs that adhere to good fidelity are more likely to achieve enhanced competitive employment outcomes.

8.4.2. **Clubhouse International Model** is dedicated to social rehabilitation for those with mental illness. A clubhouse aims to empower members by involving them in every aspect of its operations. Participation is voluntary, but each member can participate in the work of the clubhouse, which can include outreach, office work, reception, food service and much more. The daily activity of the clubhouse revolves around the work ordered day, which is an eight-hour period that models the typical business hours found in the community.

8.4.3. **Customized Employment** is a flexible process designed to personalize the employment relationship between a job candidate or employee and an employer in a way that meets the needs of both. It is based on identifying the strengths, conditions and interests of a job candidate or employee through a process of discovery. Customized employment also identifies the business needs of an employer. Together, these create a match resulting in a customized position.

8.5. **Supported Education.** Supported education is developmentally appropriate for adolescents and young adults. Some middle-aged and older adults are also interested in school or vocational training. Supported education is the process of helping individuals of behavioral health services participate in an education program so they receive the education and

training they need to achieve their learning and recovery goals and become gainfully employed in the job or career of their choice.

9. Withdrawal Management Services (WM)

9.1. **Target Population WM.** Serves adult clients who, because of their use of alcohol and/or other drugs including opioids and meet medical necessity for withdrawal management and may be frequent users of withdrawal management services, emergency medical services, public safety services, the emergency rooms of acute care hospitals, or API.

9.2. **Access WM.** Priority admissions are required in the following order for: pregnant injection drug users, pregnant women, injection drug users, and women with children. Admission to withdrawal management services will be based on the criterion delineated in the Substance-Related Disorder category as defined by the current Diagnostic and Statistical Manual of Mental Disorders (DSM 5) and the current SUD Client Placement Criterion defined by the American Society of Addiction Medicine (ASAM Third Edition).

9.3. **Continuum of Care WM.**

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

9.3.2. **Discharge Planning.** Comprehensive discharge planning will begin at admission, based on the results of the client's substance use disorder assessment, and will address matters such as referrals for SUD treatment (residential or outpatient), mental health treatment, housing, case management, initiation of family counseling, etc. As much as possible, referrals should be to specific programs or resources. Using approaches such as Motivational Interviewing will encourage and support client readiness and acceptance for engaging in additional treatment, as needed. At discharge, clients must be offered information on how to obtain HIV and TB screening, as well as harm reduction strategies to include syringe/needle exchange.

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

9.4. **Services Withdrawal Management**

9.4.1. **Residential Withdrawal Management Level of Care.** Non-ambulatory withdrawal management client services are provided by a grantee in a permanent facility with 24-hour observation and supervision by properly trained staff that provides structure and support to clients during the course of the client's treatment for withdrawal management.

9.4.1.1. **Medically Monitored Withdrawal Management Services.** A grantee offering medically monitored withdrawal management services provides observation and supervised evaluation of withdrawal management delivered by qualified medical and nursing professionals in a hospital or permanent inpatient facility, with 24-hour observation, monitoring and treatment.

9.4.1.2. **Clinically Managed Withdrawal Management Services.** Staff providing clinically managed withdrawal management services in a residential setting may supervise a client's use of self-administered medications for the control of the client's withdrawal symptoms. Staff providing clinically managed withdrawal management services must have the ability to determine the appropriateness and necessity of transferring clients in need of medical services to a hospital.

9.5. **Ambulatory Withdrawal Management.** Grantees offering ambulatory (i.e., outpatient, non-residential) withdrawal management provides services to individuals who are misusing alcohol, other drugs, or opioids, and is able to minimize the residential stays for these clients because the clients have adequate social or family support systems in place, and their medical condition does not require a higher level of (non-ambulatory) withdrawal management services. A client of an ambulatory withdrawal management grantee must be concurrently receiving outpatient or residential substance use (not withdrawal management) treatment services.

9.5.1. **Ambulatory Withdrawal Management Services without Extended Onsite Monitoring.** All grantees are required to meet the standard for ambulatory withdrawal management with extended on-site monitoring. Client has a safe place to sleep at night with family or friend support and is at the withdrawal center various hours of the day for medical staff to observe withdrawal and that the client isn't having any complications. Ambulatory withdrawal management without extended onsite monitoring is an organized outpatient service which the grantee may provide in an outpatient office, clinic, or treatment facility. Grantees offering this lower level of onsite monitoring shall use trained clinicians and medical staff who provide medically supervised evaluation, withdrawal management, and referral services according to a publicized, predetermined program. These planned services are provided in regularly scheduled sessions and are delivered under a defined set of grantee-published policies and procedures and in accordance with identified, available medical protocols.

9.5.2. **Ambulatory Withdrawal Management Services with Extended Onsite Monitoring.** Ambulatory withdrawal management with extended onsite monitoring is similar to ambulatory withdrawal management without extended onsite monitoring (above) with the following exceptions:

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

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

10. Sobering Centers

10.1. **Target Population:** Sobering centers serve intoxicated/alcohol dependent adults. These individuals are frequently homeless with secondary problems such as drug use/dependence, mental illness and/or medical issues.

10.1.1. Sobering centers are facilities that provide a safe, secure environment for meeting the needs of adults so extensively intoxicated they are unable to care for themselves for a period of time and require observation. A sobering center allows impaired individuals to safely become sober and encourage their connection to outpatient services, primary care, housing, and other community supports based on proper use of evidenced-based screening tools. Sobering centers do not meet ASAM criteria (Third Edition, 2013) for withdrawal management services, nor are they treatment facilities.

10.2. **Prerequisites.** Grantees must also use the ASAM Third Edition, adopted by reference in 7 AAC 70.910.

10.3. **Core Services and Requirements:** Support services must include the following:

10.3.1. Programs will develop an initial and ongoing collaboration with local police department, Department of Corrections, and hospital emergency departments.

10.3.2. Services must be available 24 hours per day, seven days a week.

10.3.3. Staff must be certified as emergency medical technicians (EMTs).

10.3.4. Staff should be trained in crisis de-escalation techniques and Screening, Brief Intervention, Referral to Treatment (SBIRT). Staff should also be trained in Motivational Interviewing skills.

10.3.5. Medical screening upon admission is conducted by EMT or higher-level medical staff (or completed prior to arrival at the center by hospital ED staff).

10.3.6. Clients will be screened using the SBIRT approach to facilitate engagement in outpatient care and community resources.

10.3.7. Length of stay should average 3-14 hours.

10.4. **Programmatic Goals.**

10.4.1. Provide better care for homeless alcohol-dependent persons and improve health outcomes.

10.4.2. Decrease the number of inappropriate ambulance trips to the emergency department for homeless alcohol-dependent individuals.

10.4.3. Decrease the number of inappropriate ED visits for homeless alcohol-dependent individuals.

10.4.4. Create an alternative to booking individuals arrested for public inebriation.

10.4.5. Decrease the number of alcohol-related deaths.

10.5. **Sobering Center Best Practices.** SAMHSA's Center for Substance Use Treatment (CSAT) offers Treatment Improvement Protocols (TIPs) for use with sobering centers. Sobering centers will use the following practices:

10.5.1. Motivational Interviewing.

10.5.2. Housing first philosophy.

10.5.3. Case management.

10.5.4. Inter-organizational communication.

10.5.5. Peer support.

10.5.6. Harm-reduction centered.

11. Opioid Treatment Services (OTS)

11.1. **Target Population OTS.** Beneficiaries of services or resources provided under this program type: opioid-dependent youth ages 16-18 and adults (18 years and older) and their families.

11.2. **Access OTS.** Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users, and women with children. Admission to an outpatient opioid treatment program will be based on an opioid dependence diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM V), and criterion for placement in an outpatient level of care, as defined by the American Society of Addiction Medicine Client Placement Criterion – 2, Revised (ASAM Third Edition) and Opioid Treatment Services (OTS).

11.2.1. **Residential and Outpatient Access.** Methadone and/or buprenorphine are most commonly prescribed in outpatient settings, however, individuals receiving residential, or co-occurring disorder treatments can also be concurrently enrolled in opioid treatment services while receiving the appropriate level of substance use disorder treatment.

11.3. **Continuum of Care OTS.** Includes opioid treatment programs (OTP) and office-based opioid treatment services (OBOTS). Services may be provided in outpatient or residential settings. Opioid Treatment Program services include the dispensing of methadone, a specialized opioid compound (opioid agonist) that psycho-pharmacologically occupies opiate receptors in the brain, extinguishing drug cravings and establishing a maintenance state. OTP's may also include other opioid agonist medication such as buprenorphine, and opioid antagonist medications such as naltrexone. All medications must be dispensed according the state and federal regulations and according to the medical grantee's license and waivers.

11.3.1. Opioid Treatment Programs must:

11.3.1.1. Adhere to all rules, directives and procedures set forth in Title 42 Code of Federal Regulations (CFR), Part 8, titled "Opioid Drugs in Maintenance and Withdrawal Management Treatment of Opiate Addiction."

11.3.1.2. Have a current, valid certification from SAMHSA to dispense an opioid agonist treatment medication for the treatment of addiction.

11.3.1.3. Grantees must use the Alaska Prescription Drug Monitoring Program (APDMP) for all clients upon admission to treatment, annually and for cause throughout treatment. DBH believes that using the APDMP database will assist OTPs and OBOTS in protecting client health and safety, determining client needs and treatment planning.

11.3.1.4. Shall report mortality data on clients who at the time of death were receiving methadone assisted treatment to the State Opioid Treatment

Authority Designee within 24 hours of their being notified of the client's death.

11.3.2. Office-Based Opioid Treatment Services need to be integrated to include both the general medical and psychiatric care of the client. OBOTS prescribers to provide addiction treatment services in outpatient settings.

12. Youth and Family Outpatient Substance Use Disorder Treatment (Youth Outpatient SUD)

12.1. **Target Population Youth SUD.** Serves youth who have not reached the age of 19 years; however, clients between the ages of 19-21 can be served through this program type if the assessment reflects a clear rationale for serving them in the youth program. Youth served in this program have been assessed as having a substance use disorder involving alcohol or other drugs, prescribed or over-the-counter medications, and/or household/general use products that can be ingested or used as inhalants. This program is intended to include the client's support network of family members, friends and/or employers in the treatment process.

12.2. **Access Youth SUD.** Priority admissions are required for pregnant youth who are injection drug users, pregnant youth, youth injection drug users, youth with children and referrals from the Office of Children's Services, and Division of Juvenile Justice foster care (excludes youth incarcerated in juvenile justice facilities).

12.3. **Services Youth SUD.** Services for youth with substance use disorders must follow ASAM requirements for each level of care: Early Intervention services 0.5, Outpatient Level I, Level 2.1, and Level 2.5. (Level designated by ASAM Third Edition). Each level must meet the criteria described below.

12.3.1. **Early Intervention Level 0.5.** Services at this level are tailored to individual need. Services are delivered through individual, family and group counseling and include motivational interventions, psychoeducation and exploration of risk factors and harmful consequences of substance use and/or addictive behavior. Early intervention can be provided in a range of settings, including primary care clinics, schools, corrections, and community organizations. Individuals at this level of care do not meet diagnostic criterion for a substance use or addiction disorder or there is insufficient evidence available to make a diagnosis.

12.3.2. **Outpatient Level 1.** This treatment occurs in regularly scheduled sessions usually totaling fewer than nine therapeutic and recovery support hours per week. Examples include weekly or twice-weekly individual therapy, weekly group therapy, or a combination of the two in association with participation in self-help groups. Clients live at home or in supportive housing.

12.3.3. **Outpatient Level 2.1.** Treatment consists of regularly scheduled sessions within a structured program, with a minimum of nine therapeutic and recovery support hours per week (six hours per week for adolescents). Services consist primarily of counseling and education about substance use and mental health problems. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.

12.3.4. **Outpatient Level 2.5.** Partial hospitalization programs generally feature 20 or more hours of clinically intensive programming per week as specified in the client's treatment plan. These programs typically have direct access to medical and psychiatric services. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

13. Youth Residential Substance Use Disorder Services (Youth Residential SUD)

13.1. **Target Population Youth Res SUD.** Serves youth who have not reached the age of 19 years. Youth served in this program have been assessed as having a substance use disorder involving alcohol or other drugs, prescribed or over-the-counter medications, and/or household/general use products that can be ingested or used as inhalants. This program is intended to include the client's support network of family members, friends and/or employers in the treatment process.

13.2. **Access Youth Res SUD.** Priority admissions are required for pregnant youth who are injection drug users, pregnant youth, youth injection drug users, youth with children and referrals from the Office of Children's Services, and Division of Juvenile Justice foster care (excludes youth incarcerated in juvenile justice facilities).

13.3. **Services Youth Res SUD.** Must follow ASAM requirements for either Level 3.1 Clinically Managed Low-Intensity Residential Services or Level 3.5 Clinically Managed Medium-Intensity Residential Services (levels designated by ASAM Third Edition). Each level must meet the criteria described below.

13.3.1. **Level 3.1 Clinically Managed Low-Intensity Residential Services.** Per ASAM Third Edition, programs operating at this level of care are required to provide a minimum of five hours per week of treatment services. These programs can provide experiential-based treatment activities, such as wilderness therapy, or respite services, as long as the required treatment service hours (minimum of five hours per week) are met.

13.3.2. **Level 3.5 Clinically Managed Medium-Intensity Residential Services.** ASAM does not identify a specific number of treatment service hours for Level 3.5. However, behavioral health regulations require 20 or more of hours of clinical and therapeutic rehabilitation service per week for reimbursement.

14. Women and Children Outpatient Substance Use Disorder Treatment (W&C Outpatient SUD)

14.1. **Target Population W&C SUD.** Serves women aged 18 and older who present with dependence on, or chronic, disabling use of, alcohol or other drugs, including prescription and over-the-counter medications and household/general use products that can be used as inhalants. Includes the woman's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes.

14.2. **Access W&C SUD.** Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children. Admission will be based on a substance use diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM 5) and criterion for placement in an outpatient level of care, as defined by the American Society of Addiction Medicine Client Placement Criterion – 3 (ASAM Third Edition).

14.3. **Continuum of Care W&C SUD.** Need to include services for children.

14.3.1. **Services for Children.** SUD services for women with children must address the needs of children, including:

14.3.1.1. **Screening, Assessment and Treatment for Children.** Therapeutic interventions must be available for children in custody of the women in treatment which may, among other things, address their developmental needs, and their issues of sexual and physical abuse or neglect and/or other history of trauma.

14.3.1.2. **Access to Primary Medical Care.** Women should have access to prenatal care, while receiving treatment services.

14.3.1.3. **Pediatric Care.** Children must have access to pediatric care, including immunizations.

14.4. **Services W&C SUD.** Outpatient Women and Children's ASAM Level of Care Standard: Substance use disorder services for women with children must follow the ASAM requirements described below.

14.4.1. **Outpatient Level 1.** This treatment occurs in regularly scheduled sessions usually totaling fewer than nine hours of therapeutic and recovery support services per week as specified in the client's treatment plan. The duration of treatment varies with the severity of the individual's clinical severity and function and his or her response to treatment. Clients live at home or in supportive housing.

14.4.2. **Outpatient Level 2.1.** Treatment consists of regularly scheduled sessions within a structured program, with a minimum of nine therapeutic and recovery support services hours per week.

14.4.3. **Outpatient Level 2.5.** Partial hospitalization programs generally feature 20 or more hours of clinically intensive programming per week as specified in the client's treatment plan. These programs typically have direct access to medical and psychiatric services. While receiving services, clients may choose to live with family/friends or in other supportive housing within the community.

15. Women and Children Residential Substance Use Disorder Treatment (W&C Residential SUD)

15.1. **Target Population W&C Res SUD.** This program is intended to serve women aged 18 and older who experience a substance use disorder or co-occurring substance use and mental health disorder. Children may accompany their mothers to treatment and participate as necessary in age-appropriate activities. This program is intended to include the woman's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. Duration of treatment depends upon the individual's progress in acquiring basic living skills and on her ability to apply and demonstrate coping and recovery skills.

15.2. **Access W&C Res SUD.** Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children.

15.3. **Continuum of Care W&C Res SUD.** Grantees must ensure that clients and their families receive appropriate assessments, treatment and supports, including:

15.3.1. **Employment & Training.** Supportive employment and/or vocational training services.

15.3.2. **Educational support**, including GED preparation and completion.

15.3.3. **Housing.** Safe and supported housing, including transitional housing programs and recovery housing.

15.3.4. **Medications for Addiction Treatment (MAT).** Provide access to or provide pharmacotherapy.

15.3.5. **Services for Children.** SUD services for women with children must address the needs of children, including:

15.3.5.1. **Screening, Assessment and Treatment for Children.** Therapeutic interventions must be available for children in custody of the women in treatment which may, among other things, address their developmental

needs, and their issues of sexual and physical abuse or neglect and/or other history of trauma.

15.3.5.2. **Access to Primary Medical Care.** Women should have access to prenatal care, while receiving treatment services.

15.3.5.3. **Pediatric Care.** Children must have access to pediatric care, including immunizations.

15.3.6. **Level 3.1: Clinically Managed Low Intensity Residential.** 7 AAC 138.300 (a minimum of five hours of treatment services per week). Examples are a halfway house or sober housing that offers at least five hours of rehab services. This level of care can also apply to the final phase of a 3.5 residential program, where individuals residing in a residential facility or intensive therapeutic community program are in need of reduced hours of clinical services and increased hours of employment seeking, exploring housing options and other community reintegration efforts. The primary goal of Level 3.1 is to focus on a structured recovery environment that provides sufficient stability for the recipient. Support while seeking education and/or employment is an essential feature of these programs. There is a heavy focus on ASAM Dimensions 5 and 6.

15.3.7. **Level 3.5: Clinically Managed High-Intensity Residential** 7 AAC 138.300 (20 or more hours of treatment services per week) Grantees must be approved to provide clinically managed high intensity residential services under 7 AAC 70.120 and clinic services under 7 AAC 70.030 to support the requirement for clinic services. It is not intended that all or even the majority of social and psychological problems will be resolved in the Level 3.5 treatment stay. Such complex and often lifelong challenges will need an ongoing treatment process to enhance wellness and recovery. Thus, the treatment in level 3.5 is best viewed as just one part of a person's treatment and recovery process seamlessly integrated into a flexible continuum of services (page 246 ASAM).

16. Adult Outpatient Substance Use Disorder Treatment (Adult Outpatient SUD)

16.1. **Target Population Adult SUD.** This program is intended to serve individuals aged 18 and older assessed as having a substance use disorder involving: alcohol or other drugs, including prescription and over-the-counter medications and household/general use products that can be used as inhalants. Additionally, this program is intended to include the client's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes.

16.2. **Access Adult SUD.** Admissions are prioritized for pregnant injection drug users, pregnant women, injection drug users and women with children. Admission will be based on a substance use diagnosis, as defined by the Diagnostic and Statistical Manual of Mental Disorders (DSM 5), and criterion for placement in an outpatient level of care, as defined by

the American Society of Addiction Medicine Client Placement Criterion – 3 (ASAM Third Edition).

16.3. **Continuum of Care Adult SUD.**

16.3.1. **Employment & Training.** Grantees must link to supportive employment and/or vocational training services.

16.3.2. **Educational Support.** Grantees must ensure educational support, including GED preparation and completion.

16.3.3. **Sober Housing.** Grantees must either provide or refer to sober housing.

16.3.4. **Medications for Addiction Treatment (MAT).** Grantees must provide or provide access to pharmacotherapy.

16.4. **Services Adult SUD.** Substance use disorder services must follow the ASAM requirements described below (levels designated by ASAM Third Edition).

16.4.1. **Outpatient Level 1.** This treatment occurs in regularly scheduled sessions usually totaling fewer than nine hours of clinical services per week as specified in the client's treatment plan. The duration of treatment varies with the severity of the individual's clinical severity and function and his or her response to treatment. Clients live at home or in supportive housing.

16.4.2. **Outpatient Level 2.1.** Treatment consists of regularly scheduled sessions within a structured program, with a minimum of nine treatment hours per week. Services consist primarily of counseling and education about substance use and mental health problems. Examples include day or evening programs in which clients attend a full spectrum of treatment programming but live at home or in supportive housing.

16.4.3. **Outpatient Level 2.5.** Partial hospitalization programs generally feature 20 or more hours of clinically intensive programming per week as specified in the client's treatment plan. These programs typically have direct access to medical and psychiatric services. While receiving services clients may choose to live with family/friends or in other supportive housing within the community.

17. Adult Residential Substance Use Disorder Treatment Services (Adult Residential SUD)

17.1. **Target Population Adult Res SUD.** Serves individuals aged 18 and older who experience a substance use disorder or co-occurring substance use and mental health disorder. Additionally, this program is intended to include the client's support network in the treatment process, including family members, friends and/or employers, to maximize positive outcomes. Duration of treatment depends upon the individual's progress in

acquiring basic living skills and on their ability to apply and demonstrate coping and recovery skills.

17.2. **Access Adult Res SUD.** Priority admissions are required for pregnant injection drug users, pregnant women, injection drug users and women with children. Clients requiring this level of care referred from an Alcohol Safety Action Program, Therapeutic Court, or Alaska Psychiatric Institute are also priority for admission.

17.3. **Continuum of Care Adult Res SUD.**

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

17.4. **Services Adult Residential SUD.** Must follow ASAM requirements for either Level 3.1 Clinically Managed Low-Intensity Residential Services or Level 3.5 Clinically Managed High-Intensity Residential Services. Each level must meet the criteria described below.

17.4.1. **Level 3.1: Clinically Managed Low Intensity Residential.** 7 AAC 138.300 (a minimum of five hours of treatment services per week). Examples are a halfway house or sober housing that offers at least five hours of rehab services. This level of care can also apply to the final phase of a 3.5 residential program, where individuals residing in a residential facility or intensive therapeutic community program are in need of reduced hours of clinical services and increased hours of employment seeking, exploring housing options and other community reintegration efforts. The primary goal of Level 3.1 is to focus on a structured recovery environment that provides sufficient stability for the recipient. Support while seeking education and/or employment is an essential feature of these programs. There is a heavy focus on ASAM Dimensions 5 and 6.

17.4.2. **Level 3.5: Clinically Managed High-Intensity Residential.** 7 AAC 138.300 (20 or more hours of treatment services per week). This level of care is designed to focus on stabilization of dangerous addiction signs and symptoms, initiation or restoration of a recovery process, and preparation for ongoing recovery. Level 3.5 clients may have multiple deficits which may include substance-related disorders, criminal activity, impaired functioning, and disaffiliation from mainstream values. A global change in the recipient's lifestyle, attitude and values is needed. Mental health professionals are a part of the staff milieu. It is not intended that all or even the majority of social and psychological problems will be resolved in the Level 3.5 treatment stay. Such complex and often lifelong challenges will need an ongoing treatment process to enhance wellness and recovery. Thus, the treatment in level 3.5 is best viewed as

just one part of a person's treatment and recovery process seamlessly integrated into a flexible continuum of services (ASAM Third edition, page 246).

22. Recovery Coordination

Pending

23. Crisis Response Services

23.1. **Target Population.** Beneficiaries of services or resources provided under this program type are youth and adults (all ages) who are experiencing a behavioral health and/or substance use-related crisis.

23.2. **Services.** Crisis Response Services include Peer-Based Crisis Services, Mobile Outreach and Crisis Response Services (MOCR), 23-Hour Observation and Stabilization Services (COS) and Crisis Residential and Stabilization Services (CSS) and are administered in accordance with The Alaska Behavioral Health Providers Services Standards & Administrative Procedures for Behavioral Health Services Manual.

23.2.2. **Peer-Based Crisis Services.** Peer-based crisis services include triage of the crisis, determination of needs of the individual in crisis, support, facilitation of access to other community resources or natural supports and advocacy for the individuals needs with service providers.

23.2.1.1. Peer based Crisis services are provided by a peer support specialist under 7AAC 138.400.

23.2.2. **Mobile Outreach and Crisis Response Services (MOCR).** MOCR provides triage, assessment (including assessment of suicidality, risk, and safety), de-escalation, support and referrals or linkage to community resources including a warm hand off if needed to facility-based care. MOCR is provided 24/7 and is staffed by an interdisciplinary team of qualified professionals and includes Peer Support Specialists.

23.2.2.1. **Community Based.** MOCR provides community-based intervention and may be delivered anywhere in the community where the provider and individual in crisis can maintain safety.

23.2.2.2. **Response time.** Urban teams on average must respond to client within an hour. Rural and Frontier teams are not required to respond within an hour but must document efforts taken with respect to a rapid face to face response.

23.2.2.3. **Specialized Training**. The MOCR team has training in trauma informed care, de-escalation & in harm reduction strategies, including opioid overdose response.

23.2.2.4. **Naloxone.** MOCR must be equipped and trained in the administration of naloxone.

23.2.2.5. **Follow up.** The MOCR team must provide follow up with a client within 48 hours to ensure support, safety, and confirm linkage with any referrals. This may be satisfied through a phone call with a client.

23.2.3 **23-Hour Observation and Stabilization Services (COS).** COS provides a safe, protected environment for up to 23 hours and 59 minutes in a secure environment, provides prompt assessment (including suicide and violence risk), de-escalates the individual's distress, stabilizes the crisis, and determines the appropriate level of care or service needs with a referral and warm hand-off if needed. COS is provided 24/7 via a multidisciplinary team that includes behavioral health and/or substance use disorder staff, peer supports and medical staff.

23.2.4 **Crisis Residential and Stabilization Services (CSS).** CSS provides individuals who are experiencing a behavioral health and/or SUD crisis a safe home-like environment, 24/7 medically monitored care and short-term crisis stabilization services for a period of one to seven days. CSS provides assessment, crisis intervention and crisis stabilization designed to stabilize the individual to a level of functioning that does not require inpatient hospitalization (including stabilization of withdrawal symptoms if applicable) and facilitates appropriate referrals to community service providers with a warm hand-off if needed. CSS is provided 24/7 via a multidisciplinary team that includes behavioral health and/or substance use disorder staff, peer supports and medical staff.

23.2.4.1 Providers of CSS services are expected to follow the SAMHSA Essential Expectations for Crisis Services:

23.2.4.1.1 Avoiding harm

23.2.4.1.2 Intervening in person-centered ways

23.2.4.1.3 Shared responsibility

23.2.4.1.4 Addressing trauma

23.2.4.1.5 Establishing feelings of personal safety

23.2.4.1.6 Based on strengths

23.2.4.1.7 The whole person

23.2.4.1.8 The person as a credible source

23.2.4.1.9 Recovery, resilience, and natural supports

23.2.4.1.10 Prevention

23.3 **Access.** As the State of Alaska continues to develop the Crisis Response Continuum of Care, crisis response providers are expected to coordinate with the Alaska Crisis Call Center, Careline, 988, local crisis line or other state identified centralized platform of crisis services to develop a communication pathway that ensures the ability to coordinate the availability and accessibility of MOCR, COS and CSS if an individual meets criterion for the services based on the call centers screening.

23.3.1 **Community Provider Access**. Providers of are expected to develop collaborative relationships with potential referrals along the behavioral health & substance use disorder service continuum of care including community behavioral health centers, SUD providers, emergency psychiatric providers, and first responders.

23.3.2 **Memorandum of Agreement (MOA).** MOCR and COS providers must have an established MOA with local law enforcement and/or local first responders.

23.3.3 **No Wrong Door.** The expectation of COS is to provide the community with "no wrong door" access to 24/7 behavioral health and SUD crisis assessment and stabilization care by accepting walk-ins, emergency medical services (EMS)/ambulance, fire, and police drop-offs and community referrals. The goal is for COS providers to accept all first responder or walk-in referrals (with a no rejection policy for first responders) and not require medical clearance prior to admission decreasing barriers to access to crisis stabilization services. Admissions of first responder drop-offs are ideally conducted in a dedicated first responder drop-off area.

23.4 **Continuum of Care.** Crisis Response Services are provided within a continuum of care that may include a crisis line, mobile outreach, and crisis response services (MOCR), other community behavioral health and SUD provider services, COS, CSS, and inpatient hospitalization.

23.4.1 **Least restrictive.** Crisis response services provide support and care for individuals in crisis and their families in the community while avoiding any unnecessary law enforcement involvement, use of the emergency room, and inpatient hospitalization.

23.5 **Best Practices.** Crisis Response Services are delivered in accordance with The SAMHSA Essential Expectations for Crisis Services and the National Guidelines for Behavioral Health Crisis Best Practice Tool Kit.

23.5.1 **Core Principles of Best Practices.** Providers of crisis response services will utilize the following core principles of best practices in crisis response services identified by SAMHSA:

23.5.1.1 Addressing both mental health and recovery Issues

23.5.1.2 A significant role of peer supports in the implementation of services

23.5.1.3 Integration of trauma informed care and Zero Suicide/Safer Care

23.5.1.4 Partnerships with first responders including law enforcement, dispatch, and EMS personnel