**Section 132.150 Treatment Services**

a) All services defined in this Section shall be provided and terminated in accordance with the following criteria unless exceptions are noted:

1) The services shall be provided:

A) Following a mental health assessment or Admission Note, as applicable, and consistent with the client's ITP or Admission Note, as applicable;

B) Through face-to-face, video conference or telephone contact as permitted under each specific service;

C) To clients, and their families or collaterals at the client's request or agreement; with groups of clients; or with the client's family or collaterals as it relates to the primary benefit and well being of the client and when related to an assessed need and goal on the client's ITP; and

D) Services may be provided on- or off-site, as indicated under the specific service.

2) Service termination criteria shall include:

A) Determination that the client's acute symptomatology has improved and improvement can be maintained;

B) Determination that the client's level of role functioning has significantly deteriorated to a degree where referral or transfer to a more intensive mental health treatment is indicated; or

C) Documentation in the client's clinical record that the client terminated participation in the program.

b) Crisis intervention services include interventions to stabilize a client in a psychiatric crisis to avoid more restrictive levels of treatment and that have the goal of immediate symptom reduction, stabilization and restoration to a previous level of role functioning. A crisis is defined as a deterioration in the level of role functioning of the client within the past 7 days or an increase in acute symptomatology.

1) Crisis intervention services shall be provided to clients who are experiencing a psychiatric crisis and acute symptomatology. For a child or adolescent, a crisis may include events that threaten safety or functioning of the client or extrusion from the family or the community. Children in psychiatric crisis who are believed to be in need of admission to a psychiatric inpatient facility and for whom public payment may be sought shall be provided with crisis intervention pre-hospitalization screening. The child shall be screened for inpatient psychiatric admission and shall have his or her mental health needs assessed, according to the requirements of the SASS (Screening, Assessment and Support Services) Program (59 Ill. Adm. Code 131).

2) Crisis intervention services may be provided prior to a mental health assessment and prior to a mental health diagnosis.

3) Crisis intervention services shall include an immediate preliminary assessment that includes written documentation in the clinical record of presenting symptoms and recommendations for remediation of the crisis. Crisis intervention services may also include, if appropriate, brief and immediate mental health services or referral, linkage and consultation with other mental health services.

4) The preliminary assessment shall be incorporated into the mental health assessment and ITP, as applicable.

5) Crisis intervention services shall be delivered by at least an MHP with access to a QMHP who is available for immediate consultation and clinical supervision.

6) During regular hours of operation, the provider shall be able to provide immediate face-to-face or video conference crisis intervention services. Outside regular hours of operation, the provider shall be able to provide, at a minimum, crisis assessment and referral to mental health services, as necessary.

7) Specific documentation of the delivery of crisis service must include a preliminary assessment, a description of the intervention and the client response to service.

c) Psychotropic medication services

1) Documentation requirements

A) If prescribed by a physician or an advanced practice nurse, employed by or on contract with the provider, there shall be evidence that psychotropic medication has been prescribed by the physician or advanced practice nurse per the collaborative agreement that includes physician-delegated prescription authority.

B) If a physician is employed by or on contract with the provider, there shall be evidence that psychotropic medication is reviewed at least every 90 days by a physician or advanced practice nurse.

C) Notations shall be made in the client's clinical record regarding psychotropic medication and other types of medication. Notations shall include:

i) All medication prescribed for the client;

ii) Current psychotropic medication: name, dosage, frequency and method of administration;

iii) Any problems with psychotropic medication administration and changes implemented to address these problems;

iv) A statement indicating that the client has been informed of the purpose of the psychotropic medication ordered and the side effects of the medication; and

v) Assessment of the client's ability to self-administer medications.

2) Psychotropic and other medication shall be stored under proper conditions of sanitation, temperature, light, moisture, ventilation, segregation, and security and in accordance with Department of Public Health's rules at 77 Ill. Adm. Code 300.1640.

3) Psychotropic medication administration service

A) Psychotropic medication administration consists of preparing the client and the medication for administration, administering psychotropic medications, observing the client for possible adverse reactions, and returning the medication to proper storage.

B) Psychotropic medication administration services must be provided face-to-face.

C) Psychotropic medication shall be administered by personnel licensed to administer medication pursuant to the Nurse Practice Act [225 ILCS 65] or the Medical Practice Act of 1987 [225 ILCS 60].

D) Specific documentation of the delivery of psychotropic medication administration service must include a description of the activity.

4) Psychotropic medication monitoring service

A) Psychotropic medication monitoring includes observation and evaluation of target symptom response, adverse effects, including tardive dyskinesia screens, and new target symptoms or medication. This may include discussing laboratory results with the client.

B) Psychotropic medication monitoring may be provided face-to-face or using videoconferencing, with one exception. Phone consultation is allowed for psychotropic medication monitoring when a client is experiencing adverse symptoms from psychotropic medication and phone consultation with another professional is necessary.

C) Psychotropic medication monitoring shall be provided by staff designated in writing by a physician or advanced practice nurse per the collaborative agreement. The authorized staff shall not provide the service prior to the date of the signature.

D) Specific documentation of the delivery of psychotropic medication monitoring service must include a description of the intervention.

6) Psychotropic medication training service

A) Psychotropic medication training includes training the client or the client's family or guardian to administer the client's medication, to monitor proper levels and dosage, and to watch for side effects.

B) Psychotropic medication training may be provided face-to-face or using video conferencing.

C) Psychotropic medication training shall be provided by staff designated in writing by a physician or an advanced practice nurse per the collaborative agreement.

D) Psychotropic medication training shall be provided to clients in the following areas:

i) Purpose of taking psychotropic medications;

ii) Psychotropic medications, effects, side effects and adverse reactions;

iii) Self-administration of medications;

iv) Storage and safeguarding of medications;

v) Communicating with professionals regarding medication issues; or

vi) Communicating with family/caregivers regarding medication issues.

E) Services may be provided individually or in a group setting.

F) Specific documentation of the delivery of psychotropic medication training service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

d) Therapy/counseling service is a treatment modality that uses interventions based on psychotherapy theory and techniques to promote emotional, cognitive, behavioral or psychological changes as identified in the ITP. Services shall be provided face-to-face, by telephone or videoconference.

1) Therapy/counseling services may be provided to:

A) An individual client;

B) A group of 2 or more clients; or

C) A family, including parents, spouses and siblings (client need not be present).

2) Therapy/counseling services shall be provided by at least an MHP.

3) Specific documentation of the delivery of therapy/counseling services must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

e) Community Support − CS service

1) Community Support − Services are mental health rehabilitation services and supports for children, adolescents, families and adults necessary to assist clients in achieving rehabilitative, resiliency and recovery goals. The service consists of therapeutic interventions that facilitate illness self-management, skill building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources. CS services help clients develop and practice skills in their home and community.

2) Service activities and interventions shall include:

A) Assistance with identifying, coordinating and making use of individual strengths, resources, preferences and choices in natural settings;

B) Assistance with identifying and developing existing and potential natural support persons and teams;

C) Assistance with the development of crisis management plans;

D) Assistance with identifying risk factors related to relapse, developing wellness plans and strategies and incorporating the plans and strategies into daily routines in one's natural environments;

E) Support and promotion of client self-advocacy and participation in decision making, treatment and treatment planning and facilitating learning to do this for oneself;

F) Support and consultation to the client or his/her collaterals that is directed primarily to the well-being and benefit of the client;

G) Skill building and identification and use of adaptive and compensatory strategies to assist the client in the development of functional, interpersonal, family, coping and community living skills that are negatively impacted by the client's mental illness;

H) Assistance with applying skills and strategies learned from provider-based services and interventions to life activities in natural settings; and

I) Identification and assistance with modifying habits and routines to improve and support mental health, resiliency and recovery.

3) Program requirements

A) CS services shall be provided face-to-face, by telephone or by video conference.

B) CS services may be provided to:

i) An individual client;

ii) A group of 2 to 15 clients; or

iii) A family, including parents, spouses and siblings (client need not be present).

C) A minimum of 60% of all Community Support services must be delivered in natural settings. This requirement will be monitored in the aggregate for a provider for an identified billing period separately for community support individual and community support group, but will not be required for each individual.

D) CS services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings, and at hours that do not interfere with the client's work, educational and other community involvement.

4) Staffing requirements

CS services shall be delivered by at least an RSA.

5) Specific documentation of the delivery of community support service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

f) Community Support − Residential (CSR) service

1) Community Support − Residential services consist of mental health rehabilitation services and supports for children, adolescents and adults necessary to assist individuals in achieving rehabilitative, resiliency and recovery goals. The service consists of interventions that facilitate illness self-management, skill building, identification and use of adaptive and compensatory strategies, identification and use of natural supports, and use of community resources for individuals who reside in sites designated by the public payer.

2) Interventions shall include those described in subsections (e) and (f).

3) CSR services shall be provided face-to-face, by telephone or by video conference in group or individual settings. Groups shall be composed of no more than 15 clients.

4) Eligibility criteria − Individuals eligible for CSR shall include individuals whose mental health needs require active assistance and support to function independently as developmentally appropriate within home, community, work and/or school settings and who are in public payer designated residential settings.

5) Staffing requirements − CSR services shall be delivered by at least an RSA.

6) Specific documentation of the delivery of Community Support – Residential service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

g) Community Support − Team (CST) service

1) Community Support − Team services consist of mental health rehabilitation services and supports available 24 hours per day and 7 days per week for children, adolescents, families and adults to decrease hospitalization and crisis episodes and to increase community functioning in order for the client to achieve rehabilitative, resiliency and recovery goals. The service consists of interventions delivered by a team that facilitates illness self-management, skill building, identification and use of adaptive and compensatory skills, identification and use of natural supports, and use of community resources.

2) Interventions shall include those described in subsections (d) and (e)(2).

3) Program requirements

A) CST services shall be provided face-to-face, by telephone or by video conference to an individual or family member;

B) A minimum of 60% of all Community Support Team services must be delivered in natural settings. This requirement will be monitored in the aggregate for a provider for an identified billing period, but will not be required for each individual client;

C) CST services shall occur during times and at locations that reasonably accommodate the client's needs for services in community locations and other natural settings and at hours that do not interfere with the client's work, educational and other community involvement;

D) CST shall maintain a client-to-staff ratio of no more than 18 clients per full time equivalent staff;

E) Documentation shall demonstrate that more than one member of the team is actively engaged in the direct service to the individual;

F) The CST shall conduct organizational staff meetings at least one time per week at regularly scheduled times, according to a schedule established by the team leader.

4) Eligibility criteria

Individuals eligible for CST services are those who require team-based outreach and support for their moderate to severe mental health symptoms and who, with such coordinated clinical and rehabilitative support, may access and benefit from a traditional array of psychiatric services. A less intensive service must have been tried and failed or must have been considered and found inappropriate at this time. The individual must exhibit 3 or more of the following, or must currently be residing in a DMH residential setting or in a DCFS residential substitute care living arrangement from which transition to a less restrictive setting is imminent and, were it not for living in one of these settings, be reasonably expected by history to exhibit 3 or more of the following:

A) Multiple and frequent psychiatric inpatient readmissions, including long-term hospitalization;

B) Excessive use of crisis/emergency services with failed linkages;

C) Chronic homelessness;

D) Repeat arrest and re-incarceration;

E) History of inadequate follow-through with elements of an ITP related to risk factors, including lack of follow-through, taking medications, following a crisis plan, or maintaining housing;

F) High use of detoxification services (e.g., 2 or more episodes per calendar year);

G) Medication resistance due to intolerable side effects or the individual's illness interfering with consistent self-management of medications;

H) Child and/or family behavioral health issues that have not shown improvement in traditional outpatient settings and require coordinated and supportive interventions;

I) Because of behavioral health issues, the child or adolescent is at risk of out-of-home placement, is currently in out-of-home placement and reunification is imminent, is currently in out-of-home placement and at risk of residential placement, or is in residential placement and transition to a less restrictive placement is imminent;

J) Clinical evidence of suicidal ideation or gesture in the last 3 months;

K) Ongoing inappropriate public behavior within the last 3 months, including public intoxication, indecency, disturbing the peace, etc.;

L) Self-harm or threats of harm to others within the last 3 months; or

M) Evidence of significant complications such as cognitive impairment, behavioral problems or medical problems.

5) There shall be documentation in the assessment or client record that the individual meets 3 of the above eligibility criteria.

6) Staffing requirements

CST services shall be delivered by:

A) A team approved by the public payer or its designee;

B) A full-time team leader who is at least a QMHP and serves as the clinical and administrative supervisor of the team and also functions as a practicing clinician on the team;

C) An RSA or MHP who works under the supervision of the QMHP and who works on the team in sufficient full-time equivalents to meet the required client-to-staff ratio;

D) At least one member of the team who is a Certified Recovery Support Specialist (CRSS) or Certified Family Partnership Professional (CFPP) in a program for children and adolescents. This staff person is a fully integrated CST member who provides consultation to the team and highly individualized services in the community, and who promotes self-determination and decision making; and

E) No fewer than 3 full-time equivalent staff meeting the required team components (shall include the team leader) and no more than 6 full-time equivalent staff totaling no more than 8 different staff.

7) Service exclusions

When a client is receiving CST, CS and CSR shall not be provided except under the following conditions:

A) In accordance with an ITP to facilitate transition to and from CST services; or

B) While a client is receiving services in a residential facility designated by the public payer for the purpose of stabilizing a crisis.

8) Specific documentation of the delivery of community support – Team service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

h) Assertive Community Treatment (ACT) service

1) ACT is an intensive integrated rehabilitative crisis, treatment and rehabilitative support service for adults (18 years of age and older) provided by an interdisciplinary team to individuals with serious and persistent mental illness or co-occurring mental health and alcohol/substance abuse disorders. The service is intended to promote symptom stability and appropriate use of psychotropic medications, as well as restore personal care, community living and social skills.

2) Interventions

The ACT team shall assume responsibility for assisting the client to achieve improved community functioning by providing:

A) Comprehensive assessment;

B) Individualized treatment and recovery planning;

C) Service coordination;

D) Crisis assessment and service;

E) Symptom assessment and management;

F) Supportive counseling and psychotherapy;

G) Medication prescription, administration, monitoring and documentation;

H) Dual diagnosis substance abuse services;

I) Services that support work and education related recovery goals;

J) Activities of daily living, including residential supports;

K) Social/interpersonal relationship and leisure time skill building;

L) Peer support services;

M) Environmental and other support services; and

N) Family psychoeducation.

3) Program requirements

A) ACT shall be provided face-to-face, by telephone or by video conference.

B) ACT services shall be available 24 hours per day, 7 days per week, with emergency response coverage, including psychiatric coverage. Crisis services shall be available 24 hours per day, 7 days per week.

C) A minimum of 75% of all team contacts shall occur in natural settings.

D) A minimum of 3 contacts per week shall be provided to most ACT clients and all clients shall receive a minimum of 4 face-to-face contacts per month.

E) The ACT team shall conduct organizational staff meetings at least 4 times per week at regularly scheduled times, according to a schedule established by the team leader.

4) Eligibility criteria

A) Adults who require assertive outreach and support in order to remain connected with necessary mental health and support services and to maintain stable community living and who have not benefited from traditional services and modes of delivery as evidenced by any of the following:

i) Multiple and frequent psychiatric inpatient readmissions;

ii) Excessive use of crisis/emergency services with failed linkages;

iii) Chronic homelessness;

iv) Repeat arrests and incarcerations;

v) Client has multiple service needs requiring intensive assertive efforts to ensure coordination among systems, services and providers;

vi) Client exhibits functional deficits in maintaining treatment continuity, self-management of prescription medication, or independent community living skills; or

vii) Client has persistent or severe psychiatric symptoms, serious behavioral difficulties, a mentally ill/substance abuse diagnosis, and/or high relapse rate.

B) DHS shall authorize ACT services for eligible individuals.

5) Staff qualifications

A) Each ACT team shall be approved by the public payer or its designee.

B) Each ACT team shall consist of at least 6 full-time equivalent staff. The psychiatrist and program assistant shall not be counted toward meeting the 6 full-time equivalent requirement. All teams are required to minimally consist of:

i) A full-time team leader who is the clinical and administrative supervisor of the teams and also functions as an ACT clinician. The team leader shall be a licensed clinician;

ii) A psychiatrist who works on a full or part-time basis for a minimum of 10 hours per week with the ACT team for up to 60 enrolled clients. With a waiver by the public payer, an Advanced Practice Nurse may substitute for up to half of the psychiatrist's time;

iii) A full-time registered nurse who provides services to all ACT team enrollees and who works with the ACT team to monitor each client's clinical status and response to treatment. The registered nurse functions as a primary practitioner on each ACT team for a caseload of clients. Existing ACT providers may use an LPN with 2 years experience in mental health services as part of an ACT team until July 1, 2009. After that date, a registered nurse is required as a member of the ACT team. New ACT providers shall be required to utilize an RN on all ACT teams;

iv) Four full-time staff who work under the supervision of a licensed clinician and function as primary practitioners for a caseload of clients and who provide rehabilitation and support functions; and

v) A program/administrative assistant who is responsible for organizing, coordinating and monitoring all non-clinical operations of ACT.

C) At least one of the members of the core team shall have special training and certification in substance abuse treatment and/or treating clients with co-occurring mental health and substance abuse disorders.

D) At least one of the members of the team shall be an individual qualified as a Certified Recovery Support Specialist (CRSS). This staff person:

i) is a fully integrated ACT team member who provides consultation to the ACT team and highly individualized services in the community, and who promotes self-determination and decision making; and

ii) as of January 1, 2012, shall have six months to become certified as a CRSS, if not already certified.

E) At least one member of the core team shall have special training in rehabilitation counseling, including vocational, work readiness and educational support.

F) Each team shall be expected to maintain a staff to client ratio of no more than one full time staff per 10 clients, which shall not include the psychiatrist and program assistant. As the number of clients increase, ACT teams shall add staff to maintain the required ratio.

6) Services may be provided following a determination of eligibility for ACT services and may commence prior to the completion of a mental health assessment and the ITP when immediate assistance is needed to obtain food, shelter or clothing.

7) Service exclusions

When a client is receiving ACT, other Part 132 services shall not be provided except under the following conditions:

A) In accordance with an ITP to facilitate transition to and from ACT services; and

B) While a client is admitted to a residential facility designated by the public payer for the purpose of stabilizing a crisis for a maximum of 30 days.

8) Specific documentation of the delivery of ACT service must include a description of intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

i) Psychosocial Rehabilitation service

1) Psychosocial rehabilitation (PSR) services are facility-based rehabilitative skill-building services for adults age 18 and older with serious mental illness or co-occurring psychiatric disabilities and addictions. The PSR interventions focus on identification and use of recovery tools and skill building to facilitate independent living and adaptation, problem solving and coping skills development. The service is intended to assist clients' ability to:

A) Live as independently as possible;

B) Manage their illness and lives with as little intervention as possible; and

C) Achieve functional, social, educational and vocational goals.

2) Psychosocial rehabilitation services shall include the following interventions to assist the client in achieving improved community functioning:

A) Identification and use of strengths and recovery tools and strategies to overcome challenges, improve mental health and develop skills;

B) Individual or group skill building interventions that focus on the development of skills to be used by clients in their living, learning, social and working environments, which includes:

i) Socialization, communication, adaptation, problem solving and coping;

ii) Self-management of symptoms or recovery;

iii) Concentration, endurance, attention, direction following, planning and organization; and

iv) Establishing or modifying habits and routines;

B) Cognitive behavioral intervention;

C) Interventions to address co-occurring psychiatric disabilities and substance abuse;

D) Promotion of self-directed engagement in leisure, recreational and community social involvement; and

E) Client participation in setting individualized goals and assisting his or her own skills and resources related to goal attainment.

3) Program requirements

A) Psychosocial rehabilitation services shall be provided in an organized program through individual and group interventions;

B) Services may be provided during day, evening and weekend hours;

C) Each psychosocial rehabilitation services provider shall designate a staff member to assist in assessing client needs and progress toward achievement of treatment goals and objectives.

4) Staff qualifications

A) Each psychosocial rehabilitation program shall have a clinical supervisor or program director who is at least a QMHP;

B) PSR services shall be provided by at least an RSA;

C) The clinical supervisor or program director shall be on-site at least 50 percent of the time. If a provider has multiple sites, the clinical supervisor or program director must be able to document a consistent schedule that includes on-site time at each location;

D) When the clinical supervisor is not physically on-site, the clinical supervisor or designated QMHP shall be accessible to psychosocial rehabilitation staff;

E) Each psychosocial rehabilitation program shall include at least one staff person with documented experience or training to provide services and interventions to clients with co-occurring psychiatric and substance abuse disorders; and

F) The staffing ratio for groups shall not exceed one full-time equivalent staff to 15 clients.

5) Service exclusions

Psychosocial rehabilitation service shall not be provided in combination with any of the following services:

A) Intensive outpatient; or

B) Hospital-Based Psychiatric Clinic Service Type B.

6) Specific documentation of the delivery of psychosocial rehabilitation service must include a description of the intervention, client's or family's/guardian's response to the intervention, and progress toward goals/objectives in the ITP.

j) Mental health intensive outpatient services are scheduled group therapeutic sessions made available for at least 4 hours per day, 5 days per week.

1) Mental health intensive outpatient services are for clients at risk of, or with a history of, psychiatric hospitalization who currently have ITP objectives to reduce or eliminate symptoms that have, in the past, led to the need for hospitalization.

2) Services shall be provided by at least a QMHP.

3) Mental health intensive outpatient services shall be provided with a staff to client ratio that does not exceed 1:8 for adults and 1:4 for children and adolescents. For purposes of this subsection (j) only, a child or adolescent is defined as any individual who is 17 years of age or younger.

4) Services shall be provided on a face-to-face or video conference basis.

(Source: Amended at 36 Ill. Reg. 18582, effective December 13, 2012)