

**OUTLINE:
MCCMH PLAN FOR BEHAVIORAL HEALTH SERVICES**

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MACOMB COUNTY COMMUNITY MENTAL HEALTH PLAN FOR BEHAVIORAL HEALTH SERVICES

I. OVERALL NETWORK OPERATION

A. OVERVIEW OF FUNDING FOR SERVICES

1. MCCMH administers specialty mental health services and supports to:
 - a. Adults with serious mental illness (AwSMI);
 - b. Children with serious emotional disturbance (CwSED);
 - c. Persons (both adults and children) with developmental disabilities (PwDD); and
 - d. Persons with substance use disorders who also qualify for services as a member of one or more of these populations.
2. Funding Streams
 - a. MCCMH administers Medicaid funds for hospital-based services for all Medicaid enrollees.
 - b. MCMH uses Medicaid funds for community-based services for those individuals whose mental health needs exceed the amount of community-based mental health services administered by the Medicaid Health Plans (twenty visits per year).
 - c. MCCMH provides Medicaid serves to individuals enrolled in the Adult Benefit Waiver (ABW) program. ABW program benefits are less comprehensive than services identified for other Medicaid enrollees.
 - d. MCCMH also serves individuals enrolled in Home and Community Based Medicaid Waivers, especially:
 - (1) HAB waiver for persons with Developmental Disability (capitation funding);
 - (2) Children's Waiver for children with developmental disability (fee-for-service billed to the State); and
 - (3) SED Waiver for Children with Serious Emotional Disturbance (fee-for-service billed to the State).
 - e. MCCMH administers limited Michigan General Funds for un-insured or under-insured individuals who need mental health services. The

Michigan Mental Health code specifies that those with the most serious mental health challenges must be given priority for services. Those who are not served can be placed on a wait list pending determination of available services.

- f. MCCMH administers mental health services for those enrolled in the MI-Child program at all levels of perceived severity or need.
- g. MCCMH assists families in applying for, and determining eligibility for, the Family Support Subsidy Program (FSSP). Direct funding support to families of children with severe disabilities assists the families to stay together, allows them flexibility to purchase special services at the local level, and prevents or reduces the need for more costly out-of-home placements.

B. PURPOSE AND PHILOSOPHY

- 1. Behavioral health specialty services and supports are provided under the auspices of the MCCMH Board through an array of directly-operated and contract network providers. Services are provided to consumers representing all age and disability groups which MCCMH is mandated to serve under the provisions of the Michigan Mental Health Code (PA 258 of 1974); the Michigan Department of Community Health (MDCH)-MCCMH Managed Specialty Supports and Services Contract; and the MDCH Medicaid Provider Manual, Mental Health / Substance Abuse. These groups include Adults with Serious Mental Illness (AwSMI), Children with Serious Emotional Disturbance (CwSED), and Persons (Adults and Children) with Developmental Disabilities (PwDD).
- 2. Substance use disorder services are provided by the Macomb County Office of Substance Abuse under the auspices of the MCCMH Board, through a panel of contracted service providers. Services are provided under the provisions of the Michigan Public Health Code (PA 368 of 1978).

C. GENERAL PRINCIPLES

- 1. Services to any individual who is enrolled as a consumer of the MCCMH service system are the responsibility of MCCMH, not just a single program or agency on the MCCMH provider panel. MCCMH will provide a single point of contact and on-going care management services through a centralized Access Center. Clinical consultation, including psychiatric consultation, shall be available to service providers and their staff.
- 2. The consumer of the MCCMH Board is to receive appropriate service(s) in response to his/her need regardless of where he/she lives in the county, or at what point he/she received services in the MCCMH system of care. Services are provided in the community and at multiple sites distributed across the County in such a way as to promote access. Access to services

is enhanced by action to address:

- a. Affordability (acceptable transaction costs for the consumer),
 - b. Availability (services are present in all regional areas of the county, whether rural or urban),
 - c. Accessibility (need for transportation to services is resolved by the geographical distribution of services and by bringing services to people in the community),
 - d. Accommodation (services are adapted to the characteristics of people served), and
 - e. Acceptability (services are suitable to individuals' cultural backgrounds and personal preferences).
3. MCCMH network providers shall engage consumers of MCCMH services in on-going relationships that continue through all treatment episodes and any interruptions in care. Relationships between consumers and their case managers or supports coordinators will be on-going as the consumer moves through different levels of care. These relationships shall instill hope for recovery and shall be tailored to individuals' recovery processes. Case managers or supports coordinators stay with the consumer across care episodes.
 4. Services are to be delivered in a welcoming manner. MCCMH providers will address a consumer's multiple goals in a single setting or through a single service team. MCCMH providers will deliver services on a schedule to meet the level of urgency in a consumer's life situation. Services are designed and provided to be flexible and meet the changing needs of the consumers. MCCMH and its providers will incorporate integrated treatment in system planning, program design, clinical procedure, and clinical competency.
 5. Opportunities for collaborative service planning and service provision using a person-centered planning process are fostered in MCCMH organizations or programs, both public and private. Person-centered planning is to be implemented as life planning for wellness, recovery, self-determination, or resiliency. A consumer's person-centered plan is to address goals, objectives, and actions important to that individual even when MCCMH services are not directly related to those goals and objectives. Consumers should have opportunities to include Wellness Recovery Action Planning into the process.
 6. Recovery from mental illness and substance use conditions occurs in stages. MCCMH providers will match treatment interventions to the individual's stage of recovery and his / her cultural background. Treatment

providers must accommodate stages of recovery for both mental health and substance use conditions.

7. MCCMH supports persons served so that they can develop recovery, resiliency, and wellness. This occurs in the context of respectful, egalitarian relationships which build hope and foster self-direction. Supports may include environmental supports, verbal prompts, written expectations, clarity of rules and expectations, or praise and encouragement. Even with supports, individuals may experience fear, anger, or pain, which may lead to aggression or agitation. Staff members are prepared to recognize and respond with active listening, redirection, and other de-escalation techniques. In an emergency involving threats of harm to self or others, approved non-violent emergency physical intervention techniques may be used by persons who have received appropriate training. No form of seclusion or restraint may be used. Repeated use of emergency non-violent physical management techniques with a particular consumer must lead to behavioral analyses and to the development of behavior treatment plans designed to eliminate the use of emergency physical management with consumers. Emergency physical management should be implemented without undue force, for the purpose of comforting the consumer and /or to prevent self-injurious behavior or injury to others.
8. For additional principles related to substance use, abuse or dependence, please see the MCOSA Manual and documentation maintained in the MCOSA Office.

D. PHILOSOPHY OF SERVICES FOR ADULTS WITH SERIOUS MENTAL ILLNESS

1. Serious mental illness is a chronic condition which will have periods of exacerbation and remission over the course of a person's life. The effect of serious mental illness on individuals' functioning can be reduced through actions by individuals, peers, families, and communities. Services for adults with serious mental illness will be designed to foster and support recovery from serious mental illness.
2. Recovery is:
 - a. A process "in which people are able to live, work, learn, and participate fully in their communities" either with or without ongoing symptoms (New Freedom Commission) and where people may "reestablish a new and valued sense of integrity and purpose within and beyond the limits of the disability," (P. Deegan) or may "develop new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness." (W. Anthony)

- b. Based on hope and the rediscovery of meaning and purpose after experiences of serious mental illness. As such it is “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles.” (W. Anthony) It is not a linear process but involves regrouping and starting again after exacerbations. (P. Deegan)
 - c. Supported not only by clinical care but also by family support, peer support and relationships, meaningful activity or work, reduction or elimination of both external and internalized stigma, community, individual empowerment and community involvement.
 - d. Influenced by good (stable, safe, decent) housing, adequate income (financial independence), physical health and safety, community integration, and social support.
 - e. Facilitated by empowerment of consumers to exercise their own self-direction and self responsibility, along with peer support from others who are also on the recovery journey.
- 3. Services which support recovery are strength-based, individualized, holistic (including physical, Aological and spiritual aspects), and respectful (to support consumers’ self-respect/self-esteem).
 - 4. Consumers’ responsibility for their own recovery leads to consumers’ evaluation of the quality of services and supports provided and to consumer leadership at all levels of the system.

E. PHILOSOPHY OF SERVICES FOR PERSONS WITH DEVELOPMENTAL DISABILITIES / SELF-DETERMINATION

- 1. Services for persons with developmental disabilities foster and support self-determination. The core elements of self-determination are:
 - a. Freedom to choose a meaningful life in the community;
 - b. Authority over a targeted amount of dollars;
 - c. Support to organize resources in ways that are life enhancing and meaningful to the individual with a disability;
 - d. Responsibility for the wise use of public dollars and recognition of the contribution that individuals with disabilities can make to their communities;
 - e. Confirmation of the important leadership role that individuals with disabilities and their families must play in a newly re-designed system and support for the self-advocacy movement.

2. A person-centered planning process helps the individual consumer identify services and supports that promote community inclusion and participation, independence, and/or productivity. The outcome of the supports and services should be that the person is able to lead a meaningful life.
3. MCCMH shall make available a range of tools such as:
 - a. A flexible support service system that is rapidly responsive to the consumer's needs, wishes and desires;
 - b. A support service system that is operating within the least restrictive, non-segregated environments for the consumer;
 - c. A personal and individualized budget for the consumer's support services (and, if desired, a fiscal intermediary service to assist him/her to manage the personal budget).
4. MCCMH has developed mechanisms for adult consumers seeking to direct their own supports through the use of contractual Self-Determination agreements, and the use of fiscal intermediaries. See section I.I., "Principles for Consumer-Directed Care," below.

F. PHILOSOPHY OF SERVICES FOR CHILDREN WITH SERIOUS EMOTIONAL DISTURBANCE

1. Services for children with serious emotional disturbance are intended to improve resilience and development of children with serious emotional disturbance and their families. "Resilience":
 - a. Refers to the personal and community qualities that enable individuals to rebound from adversity, trauma, tragedy, threats, or other stresses — and to go on with life with a sense of mastery, competence, and hope;
 - b. Is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem solving skills, and treatments;
 - c. Is a quality of closely-knit communities and neighborhoods which provide supports for their members.
2. Services for children with serious emotional disturbance will be delivered by MCCMH as part of a comprehensive, integrated system of care within Macomb County.
 - a. The mental health component of the system of care will be family-centered (family-driven, youth-guided), with full participation of the child/youth and his/her family in decision-making regarding service

design and service operation;

- b. Services will be community-based – the responsibility for the focus of services, their management, and overall decision-making responsibility rests at the community level – and resources and funding are shared across systems at both the state and local level;
- c. Services will be culturally and linguistically relevant – cultural competency is achieved through the responsiveness of agencies, programs, and services to the cultural, racial, and ethnic differences of the populations they serve – and children/youth and their families are served in the community in which they live;
- d. Children/youth and their families have access to a comprehensive array of services that address their physical, emotional, social and educational needs, but services are individualized to meet the unique needs of the children/youth and their families;
- e. Children/youth are identified early, provided comprehensive assessment and, if indicated, provided needed services. Transition to adult services/system is facilitated and actively planned for the individual no later than his/her 16th birthday;
- f. Evidence-based, promising practices are implemented with fidelity to the model. Outcomes and indicators are established and measured.

G. PRINCIPLES FOR CO-OCCURRING MENTAL HEALTH / SUBSTANCE USE DISORDERS

- 1. MCCMH will implement treatment for individuals with these co-occurring disorders throughout all levels and modes of care within its network of behavioral health and substance abuse providers.
 - a. All providers will be capable of initiating dual disorder interventions that engage individuals with co-occurring disorders in the recovery process;
 - b. Specific providers at each level of care will also be able to provide substance abuse treatment along with mental health services (enhanced dual disorder treatment capability);
 - c. Select providers within the behavioral health provider network will implement the SAMHSA “tool-kit” for treating co-occurring disorders among adults with serious mental illness.
- 2. MCCMH will provide integrated treatment for individuals with co-occurring serious mental health and substance use disorders. Integrated treatment

is delivered by one treatment team in one setting and assumes that when mental health and substance use disorders co-exist simultaneously, each is primary.

3. In every clinical contact, MCCMH providers will welcome individuals with co-occurring mental health and substance use disorders by approaching and engaging them in an on-going treatment relationship that will facilitate overall recovery.
4. Recovery from mental health and substance use disorders occurs in stages. Therefore, MCCMH providers will match treatment interventions to the individual's stage of recovery and his / her cultural background. Treatment providers must accommodate stages of recovery for each co-occurring disorder, even when they are not synchronized.
5. The goal of integrated dual disorder treatment is to reduce symptoms of both mental health and substance use disorders and improve individuals' functioning. This may include improvement in disease management skills, increase in treatment participation, reduction in risk of harm, and other positive outcomes.
6. The provision of dual-disorder enhanced services will be delivered by individuals/provider programs who are appropriately credentialed and licensed through MDCH, Health Systems & Health Profession Licensing, Health Care Facilities and Programs, SA Program Licensure.

H. PRINCIPLES FOR HOUSING-RELATED SERVICES

1. Principles for housing-related services include integrated physical and behavioral health care.
2. MCCMH consumers should be respected and supported to have ultimate control of where they live and with whom they live (if anyone). Consumers must be able to change the provider of their specialty mental health services and supports without having to relocate to different housing. The provider of housing should not be the provider of specialty mental health services and supports. Community Living Facilities for adults with SPMI are treatment settings and must assist the consumer with the transition to independent living.
3. MCCMH consumers should be respected and supported to acquire and retain safe, decent, affordable housing of their choice within reasonable time frames. That choice should include all types of housing stock, including single-family detached homes, town homes, condominiums, manufactured homes, mobile homes and apartments. Appropriate supports should include access to mortgage lenders, as well as assistance with on-going maintenance issues and exercising and performing their rights and responsibilities as tenants or homeowners.

4. MCCMH consumers who are homeless should be respected and supported in obtaining rapid re-housing. MCCMH should support the Macomb County Continuum of Care and other public housing initiatives by coordinating the provision of specialty mental health services and supports for residents with those housing efforts.
5. By respecting and supporting the housing preferences and choices of people with disabilities MCCMH truly fulfills the mandates of the ADA with respect to community integration.

I. PRINCIPLES FOR CONSUMER-DIRECTED CARE

1. MCCMH has developed mechanisms for consumers seeking to direct their own supports through the use of contractual Self-Determination agreements.
2. Self-Determination is available to MCCMH adult consumers (both those with mental illness and those with developmental disabilities) who request the opportunity to participate (it is a voluntary option), and for whom an agreement, using a person-centered approach, can be reached on a plan of services and supports, and an acceptable individual budget.
3. The person-centered planning meeting (facilitated by persons trained in the concepts and values of Self-Determination) is used for the development of an explicit Self-Determination agreement that meets the requirements of the MDCH-MCCMH Prepaid Health Plan contract. The written agreement includes the participant's plan, individual budget, and delineates the responsibility and authority of both MCCMH and the participant in the application of the individual budget. Model agreements assure that provider entities or individuals selected meet applicable provider qualifications pertinent to the particular professional services, and that fees/rates negotiated are within the boundaries of the authorized individual budget and within the range of rates considered applicable by MCCMH. The plan and budget are in effect for a defined period of time, typically one year.
4. The amount of the individual budget is formally accepted by both the participant and MCCMH, and accompanies the participant's plan of services and supports. The budget is to be flexible in use, and may be reopened and reconsidered whenever the participant or MCCMH believes it needs to be reconsidered. Flexibility in the use of budget funds may be constrained by the specific limitations of certain funding sources (e.g., Vocational Rehabilitation, Home Help, etc.) where the funds aggregated and used to finance an individual budget are controlled by more than one funding source. (MCCMH and the participant share accountability for the use of public funds.)
5. Alternative methods are available for the participant to use to control his/her individual budget:
 - a. The participant can act as the employer of record of personnel by

executing a direct purchase-of-services agreement with a participant-selected provider. Participants assure that written agreements are developed with each person / entity that specifies the type of service or support, rate to be paid, and requirements incumbent on the parties. Participants assure that persons / entities retained meet provider qualifications. MCCMH provides guidance as to the range of applicable rates and maximum amounts that a participant may spend to pay specific providers.

- b. The participant can choose to use provider entities (“staffing agencies” with developed associations with MCCMH) that may serve as employer of record for the personnel selected by the participant for the delivery of the planned/authorized services and supports.
 - c. The participant may utilize a qualified provider chosen by the participant, with MCCMH agreeing to enter into a contract with that provider.
 - d. The participant may choose to use an entity/individual currently operating as or under contract with MCCMH.
6. The participant may elect to contract with a qualified third-party business agent to act as a fiscal intermediary (as authorized, made available, and trained by MCCMH) in order to assist the participant to manage service budgets, perform payroll agent functions, pass financial payments from the payer to the providers, and provide additional employer supports. The participant may also elect to self-manage these transactions where appropriate. (A fiscal intermediary must be free from any relationships that would create a conflict of interest with supporting participant-determined services and supports transactions.)
 7. The self-determination agreement may be terminated by either MCCMH or the participant. MCCMH, prior to terminating an agreement, shall inform the participant of the issues leading up to the consideration and, unless not feasible, provide an opportunity for problem resolution.

J. PRINCIPLES FOR TRAUMA-INFORMED AND TRAUMA-SPECIFIC CARE

1. MCCMH is implementing trauma-specific services for consumers who have reported prior exposure to trauma-inducing situations and current effects on experience (e.g., increased anxiety, periods of panic) or performance (e.g., avoidance of fear-inducing situations) consistent with them.
2. One example of this implementation is the incorporation of Trauma-Focused Cognitive Behavior Therapy for children and youth into both home-based and outpatient clinic services for those populations. This includes the initiation of screening for traumatic experiences during initial telephonic screenings and the use of trauma assessment tools during treatment. It also involves parent resource trainers who meet with parents in a group

format to provide information, process its meaning, and strengthen parent-to-parent supportive relationships.

3. The implementation of such trauma-specific services is leading to a trauma-informed service delivery system. In such a system, procedures for screening, assessing, and serving consumers are modified to respect the likelihood of previously un-identified traumatic experiences in consumers and to reduce the likelihood of re-traumatization.

K. PRINCIPLES FOR FAMILY PSYCHO-EDUCATION SERVICES

1. Family Psycho-Education (FPE) is a structured problem-solving intervention delivered to consumers and to their families in a group format. Individuals and their families are recruited and prepared through several preliminary “joining” sessions. All the individuals and families who will meet in the year-long group meet in an “all-day” workshop that provides information on serious mental illness, medications, services, recovery, as well as other issues, and also provides for the development of group cohesion among the participants in the on-going, bi-weekly problem-solving group.
2. MCCMH has implemented the Family Psycho-Education Evidence-Based Practice for Adults for Serious Mental Illness. The implementation began with consumers and their families in both outpatient clinic settings and in community-based residential settings. FPE is also being tested with consumers who are just entering services.
3. Staff who provide Family Psycho-Education must complete training approved by the Michigan Department of Community Health and participate in a year-long supervision process.

II. MCCMH CORE SERVICES

Core Services administered by MCCMH include a variety of services usually delivered by professional staff in an office environment and / or under the oversight of a physician. These services include evaluations and on-going treatments provided by psychiatrists, psychologists, psychiatric nurses, and psychotherapists. These services also include evaluations and on-going treatments provided by ancillary health professions, such as occupational therapy, physical therapy, and speech and language services. All services are developed through a person-centered planning process.

A. CARE MANAGEMENT SERVICES

1. Screening and Referral
The Access Center provides centralized initial telephone response to individuals seeking mental health, substance abuse, and/or developmental disability services from MCCMH. All routine, urgent and emergent service requests are answered by professional staff who provide telephone triage,

conduct brief risk assessment, obtain general client/consumer information and provide referral/authorization for appropriate MCCMHS services.

2. **Level of Care Determination / Re-Determination**
The Access Center provides level of care determination or re-determination, and continued stay approval for service providers to assure the delivery of appropriate MCCMH services. It additionally provides a clinical review of prior level of care denials in response to provider requests.
3. **Authorization of Payment for Services**
The Access Center authorizes payment for services approved in the service array, and provided by the MCCMH contract provider, between the effective date and the lapse date of the authorization.
4. **Jail Diversion**
 - a. **Adult Jail Diversion**
 - (1) The MCCMH adult jail diversion liaison assists local law enforcement, district court, and circuit court personnel to divert persons with serious mental illness, co-occurring substance use disorder, and /or developmental disabilities who may be arrested for non-violent misdemeanors from legal proceedings or incarceration to appropriate mental health treatment.
 - (2) The MCCMH jail diversion liaison identifies persons with a history of serious mental illness, co-occurring substance use disorder, and / or developmental disability as they enter the criminal justice system. The liaison reviews available clinical information, and recommends appropriate mental health services for consideration during hearings through the court system. The liaison may also review the consumer's progress in court-ordered treatment and assist the court with continuation reviews of those court orders.
 - b. **Juvenile Jail Diversion**
 - (1) The MCCMH juvenile diversion liaison assists local law enforcement, district court, and circuit court personnel to divert children with serious emotional disturbance, co-occurring substance use disorder, and /or developmental disabilities who have been referred or arrested for issues under the jurisdiction of the juvenile justice system.
 - (2) The MCCMH juvenile jail diversion liaison identifies children with a history of serious emotional disturbance, co-occurring substance use disorder, and / or developmental disability as

they enter the juvenile justice system. The liaison reviews available clinical information, recommends appropriate mental health services for consideration during hearings for juveniles through the court system. The liaison may also review the consumer's progress in court-ordered treatment and assist the court with continuation reviews of those court orders.

5. Court Liaison

- a. The MCCMH court liaison provides assistance to parties involved in legal processes regarding involuntary mental health treatment. The liaison assists persons being considered for involuntary mental health services to understand the legal process and their rights as recipient(s) of services. The liaison assists representatives of the Macomb County Courts to understand the services available to individuals being considered before the Court for orders for mental health treatment.
- b. The MCCMH court liaison reviews available clinical information, is available to attend deferral meetings, makes recommendations to Probate Court, and assists consumers who face the potential for involuntary treatment to protect their options during legal proceedings. The court liaison also reviews consumer progress in court-ordered treatment and assists the court with continuation reviews of those court orders.

B. ASSESSMENTS

1. Core Assessment / Re-Assessment (Psychosocial Assessment)
A Core Assessment / Re-Assessment is the systematic collection and evaluation of detailed and pertinent data describing the recipient's current identifying information, presenting problem, mental status, psychiatric history, physical health, medications, psychosocial history; recipient and family psychiatric, medical, and substance use/abuse history. The information gathered in this process is analyzed by the practitioner to assess the individual's therapeutic needs assessment for the purpose of defining and clarifying consumer-identified problems and service needs in preparation for request for authorization of a service package.
 - a. The Substance Abuse section is designed to identify those consumers whose history or presentation suggest a need to clarify present substance use/abuse.
 - b. The Support Needs Worksheet is included for persons with developmental disabilities, persons with SMI living in licensed residential setting, and for those needing assessment of basic skills.

It helps to identify challenges in the person's functional status.

- c. The Child/Adolescent Function Assessment Scale (CAFAS) is included for children with serious emotional disturbance.

2. Psychiatric Evaluation

A Psychiatric Evaluation is an assessment, including comprehensive interviews, conducted by a psychiatrist for the purpose of determining mental, emotional, and behavioral functioning and capacities; the presence or absence of pathology; and recommending a course of treatment.

3. Health Assessment

A Health Assessment is the systematic collection and evaluation of data about health status of consumers derived from a review of body systems. The assessment documents the consumer's current/past medication history, denotes any known allergies and any substance use (alcohol/drug). The assessment identifies any present health care problems and recommends a course of treatment which promotes the maximum health of the consumer.

4. Psychological Assessment/Testing

A Psychological Assessment/Testing is the systematic administration, scoring and interpretation of structured, standardized, appropriately normed psychological instruments. These instruments have generally accepted reliability and validity to measure intellectual function, neuropsychological function, personality function, and vocational interest/aptitudes.

5. Behavioral Analysis

A Behavioral Analysis is the systematic analysis of personal behavior in terms of antecedents (cues, stimuli), activity components, consequences (reinforcers, punishers), sustaining factors, and patterns for the purpose of constructing a behavioral intervention plan that will lead to the changes in behaviors that are undesirable, unproductive, or a hazard to self or others. Behavioral interventions that include intrusive, aversive or restrictive measures must be reviewed and approved by the Behavior Management Review Committee.

6. Speech and Language Assessment

A Speech and Language Assessment is the collection and evaluation of data regarding a consumer's ability to process language, fluency, expressive language, articulation; and ability to understand and follow directions with recommendations for a course of treatment.

7. Occupational Therapy Assessment

An Occupational Therapy Assessment is the systematic collection and evaluation of data regarding a consumer's physical function, activities of daily living, cognitive/perceptive functioning, interpersonal/social skills, task behaviors and pre-vocational skills with recommendations for a course of treatment

8. **Physical Therapy Assessment**
Physical Therapy Assessment is an evaluation of the consumer's need for services that are anticipated to result in a functional improvement that is significant to the consumer's ability to perform daily living tasks appropriate to the consumer's chronological, developmental or functional status.

C. COORDINATION AND PLANNING SERVICES

Planning / coordination services administered by MCCMH include a range of services designed to sustain the individual in a community-based environment. These services include targeted case management, supports coordination, and wraparound services for children. Peer support specialists are also available for the provision of support and assistance. All services are provided utilizing the person-centered planning process.

1. **Case Management (AwSMI)**
Case management services assists consumers who have multiple service needs, who are highly vulnerable, and who are likely to have difficulty accessing and sustaining needed services on their own. Case management services assist in designing, accessing, and implementing strategies to build or maintain self-sufficiency and independent healthy roles in their own community.
2. **Support Coordination (PwDD)**
Support Coordination is case management for persons with developmental disabilities. Support coordination assists with the development, implementation, and nurturance of the supports needed for the persons served to become independent, self-sufficient, and integrated into the community.
3. **Wraparound (CwSED)**
Wraparound services for children and adolescents is a highly individualized planning process performed by supports coordinators who coordinate the planning for, and delivery of, wraparound services that are medically necessary for the child. The overall goal of Wraparound is to encourage and nurture the development of a unified service system that collaborates with families and pools resources to meet the individual needs of children with serious mental, emotional, developmental and/or behavioral disorders, and their families.
4. **Certified Peer Support Specialists**
 - a. Peer support specialist services provide consumers with opportunities to support, mentor and assist them to achieve community inclusion, participation, independence, recovery, resiliency and productivity. Because peers have a unique background from their own experience utilizing services and

supports to achieve their personal goals, peers are able to gain trust and respect from MCCMH consumers based on shared experience with mental illness, disabilities, and with planning and negotiating human services systems. Specific services that peer supports assist with include but are not limited to:

- Vocational assistance
- Housing assistance
- Person-centered planning process
- Developing self-determination arrangements
- Directing support staff
- Sharing recovery and/or advocacy involvement in assisting recovery and self-advocacy
- Accessing entitlements
- Developing crisis plans and advance directives

- b. Peer support specialists are chosen by the consumer, and where serving consumers with mental illness, meet MDCH specialized training and certification requirements.

5. Person Centered Planning

- a. Person-centered planning consists of an on-going planning process that identifies the consumer's long-term goals (dreams, wishes) and develops practical strategies for achieving those goals as part of the process of recovery, development and resilience building, and self-determination. Plans specify the scope, amount, and duration of services and supports needed to achieve measurable outcomes related to the consumer's goals. Consumers assist in preparing for the person-centered planning process through a pre-planning process, which includes identifying who is to be invited, who will facilitate the process, and what issues are to be addressed. Case managers provide assistance with person-centered planning as part of the case management process. Plans are made on a yearly basis and are reviewed as needed, or on a quarterly basis in specific services, such as Assertive Community Treatment (ACT), so that progress toward goals can be monitored and adjustments in strategies and actions can be made. The plan for children should consider the family context and the child's educational needs. Person-centered planning is a partnership between consumers and staff that specifies which services will be arranged for consumers, by whom, and in what scope, amount, and duration. Person-centered planning is a primary service since it includes the coordination of a wide variety of activities designed to assist consumers in reaching their goals. This should include specific services and supports not administered by MCCMH as well as those that are.

- b. Consumers lead the person-centered planning process through a pre-planning process, which includes identifying who is to be invited, who will facilitate the process, and what issues are to be addressed.
- c. Case managers provide assistance with person-centered planning as part of the case management process.
- d. Plans which are developed from the person-centered planning process specify the scope, amount, and duration of services and supports needed to achieve measurable outcomes related to the consumer's goals.
- e. Plans are made at least on an annual basis (or on a quarterly basis in specific services, such as ACT) but can be renewed as needed, so that adjustments in strategies and actions can be made to maximize progress toward goals.
- f. The planning process for children shall consider the family context and the child's educational needs.

D. MEDICAL SERVICES

The following Medical Services may be available to MCCMH consumers:

- 1. **Medical Assessment**
Medical Assessment services include Psychiatric Evaluation and Health Assessment (see section II.B.2 and II.B.3., above).
- 2. **Medication Review**
Medication Review is an evaluation of the consumer's compliance with medication, side effects or adverse reactions, pertinent lab work-up and results, current physical and mental status, response to medication using identified (written) target symptoms as baseline, and rationale for continuing, discontinuing, changing, or adding medication.
- 3. **Medication Administration**
Medication Administration refers to the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a consumer.
- 4. **Nursing Services**
Nursing Services are services performed by training and certified nursing staff within the scope of their practice, including RN Services, Medication Training and Support, Medical Nutrition Therapy, and Patient Education (either individual or in groups). Private Duty Nursing is available to individuals enrolled in the HAB Waiver who are age 21 and older to meet an individual's health needs directly related to a developmental disability, in

conjunction with Community Living Supports or Skill-Building services (out-of-home non-vocational habilitation or pre-vocational or supported employment.)

E. THERAPY SERVICES

Therapy services are designed to reduce maladaptive behaviors, to maximize skills in behavioral self control, or to restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the consumer to function more appropriately in interpersonal and social relationships.

1. **Crisis Intervention Services**
Crisis Intervention Services are designed for the purpose of resolving a crisis situation requiring immediate attention, including crisis response via telephone or face-to-face, assessment, referral, and direct therapy services.
2. **Individual Psychotherapy**
Individual Psychotherapy is a face-to-face counseling services with the consumer.
3. **Group Psychotherapy**
Group Psychotherapy is a face-to-face counseling with three or more consumers, and can include didactic lectures, therapeutic interventions, counseling, and other group related activities.
4. **Family Psychotherapy**
Family Psychotherapy refers to face-to-face counseling with the consumer and the significant other and/or traditional or non-traditional family members.
5. **Occupational Therapy**
Occupational Therapy refers to services rendered by a registered occupational therapist or certified occupation therapy assistant that are active and restorative, and include training activities of daily living, fabrication of adaptive equipment, perceptual motor training, and therapeutic exercises.
6. **Physical Therapy**
Physical Therapy refers to services rendered by a licensed physical therapist (physical therapy assistant or a supervised physical therapy aide) with the expectation that the consumer's condition will improve significantly in a reasonable and generally predictable period of time. Examples of physical therapy include range of motion exercises for specific disabilities, and gait training where the consumer's ability to walk has been impaired by neurological, muscular, or skeletal abnormality.
7. **Speech and Language Therapy**
Speech and Language Therapy refers to services rendered by an

appropriately certified speech pathologist that are active and restorative and include treatments for cerebral vascular accident or trauma, neurological disease, voice disorders, or maxillofacial abnormalities.

F. SUPPORT SERVICES

1. **Community Living Supports**
Community Living Supports (CLS) are services provided by trained paraprofessional staff to assist the person with various activities of daily living, instrumental activities of daily living, or community-inclusion activities. Community Living Supports typically involves observing, prompting, reminding, and training with these tasks. Community Living Supports can involve direct hand-on assistance with tasks but cannot supplant hands-on assistance purchased by the Department of Human Services for consumers who are eligible for Adult Home Health and similar programs.
2. **Respite Services**
Respite services are services provided to caregivers who reside with consumers and provide unpaid assistance to them on a daily basis. Respite services assist these caregivers to “rest a bit” and reduce the overload and burnout often experienced by those assisting persons with mental illness and / or developmental disabilities in the community. Since respite services are for the care-giver rather than the consumer, there is less specificity about consumer outcomes than with Community Living Supports. Respite services do not supplant community living supports or other services. Respite services are provided in appropriate settings (the individual’s home or place of residence, a licensed family foster care home, home of a friend or relative, or in the community with a trained respite worker.)
3. **Family Training**
Family training provides for direct instruction to members of the consumers’ family and natural supports system that will support the consumer’s activity in the community. The consumer’s individual plan of service identifies the family support and training necessary to assist the individual in achieving his/her goals; the plan of service identifies the training and counseling goals, the content, frequency and duration of the training.
4. **Skill Building Services**
Skill building services include training and practice of general work-skills and transitional supports (e.g., job coaching and follow-along services) designed to assist individuals to establish themselves in a competitive or supported work-environment. The skill training typically focuses on skills needed in a variety of workplace environments (e.g., timeliness, persistence and pace, problem-solving in the workplace, social interactions with co-workers and supervisors) rather than on skills specific to a particular job role or function (e.g, masonry). (Consumers may not currently be eligible for sheltered workshop services provided by Michigan Rehabilitation Services to be eligible for skill building services.)

5. Supported / Integrated Employment

- a. Supported Integrated Employment Services provide job development, initial and ongoing support services, and activities as identified (in amount, scope and duration) in the individual plan of service. The goal of supported / integrated employment services is to assist consumers to obtain and maintain paid employment that would otherwise be unachievable without such supports. Support services are provided continuously, intermittently, or on a diminishing basis as needed throughout the period of employment. Supported / integrated employment is provided in integrated work settings where the consumer is working alongside people who do not have disabilities.
- b. Support services include:
 - (1) The provision of assistance (to consumer / employer) in episodic occurrences of need.
 - (2) Job development, placement, and coaching
 - (3) Consumer-run businesses
 - (4) Transportation

6. Assistive Technology

- a. Assistive Technology is an item(s) that allows the consumer to increase his/her ability to perform his/her activities of daily living functioning, as specified in the individual plan of service and as ordered by a physician on a prescription. (Order valid for one year.)
- b. Coverage includes:
 - (1) Vehicle adaptations
 - (2) Lifeline, sensory integration equipment
 - (3) Communication devices
 - (4) Special personal care items needed to accommodate the person's disability
 - (5) Prostheses necessary to remove the negative visual impact of serious facial disfigurements
- c. Not covered are recreational choice items, vehicular repairs / maintenance, or furnishings that are non-custom items and routinely found in homes.

7. Environmental Modifications

- a. Environmental Modifications are physical adaptations to the consumer's home or apartment and/or work place according to a physician prescription. Prior to the environmental modification being authorized, MCCMH may require that the beneficiary apply to all

applicable funding sources (e.g., housing commission grants and community development block grants), for assistance. It is expected that the case manager/supports coordinator will assist the beneficiary in his pursuit of these resources. The environmental modification must prove to be the most cost effective way of meeting the individual's needs.

- b. Examples of environmental modifications include the installation of ramps and grab-bars, widening of doorways, modification of bathroom facilities, special floor, wall or window covering, assessments, specialized training, home construction. The environmental modifications are done through a signed contract with the builder and the homeowner, and must comply with applicable state or local building codes.

8. **Enhanced Health Services**

Enhanced Health Services provide funding for extra-ordinary health-related expenses. These enhanced supports are directed at various forms of assistive technology; i.e., Personal Emergency Response Systems, durable medical equipment, environmental modifications, and funding for health-related expenses (even over-the-counter) beyond the typical coverage limits of health insurance. These supports are funded under a special funding review following appropriate evaluations by medical personnel such as nurses, occupational therapists, and physicians.

9. **Durable Medical Equipment**

Durable Medical Equipment includes but is not limited to iron lungs, oxygen tents, hospital beds, seat-lift mechanisms on seat-lift chairs, and wheelchairs used in the consumer's home, or in an institution used as the consumer's home (other than an institution such as a hospital where the consumer is an inpatient), whether furnished on a rental basis or purchased. It also includes blood-testing strips and blood glucose monitors for individuals with diabetes.

10. **Housing Assistance**

- a. Housing assistance is assistance with short-term, interim, or one-time-only expenses for consumers transitioning from restrictive settings and homelessness into more independent, integrated living arrangements while in the process of securing other benefits (e.g., SSI) or public programs (e.g., governmental rental assistance and/or home ownership programs) that will become available to assume these obligations and provide needed assistance. The consumer has an individual plan of service that contains a goal for independent living, and the consumer owns, rents or leases the apartment that he/she is living in, or, can show that he/she is in the process of transitioning to such a setting. (See also section I.H. herein, "Principles for Housing-Related Services.") Housing Assistance

funds administered by MCCMH assist consumers to rent apartments in the community under their own name, usually with one or two roommates. Consumers who are assisted in this manner typically receive a variety of other services from MCCMH, as described below.

b. Coverage includes but is not limited to:

- (1) Assistance with utilities
- (2) Insurance
- (3) Moving expenses (in some situations)
- (4) Temporary assistance with living expenses for beneficiaries transitioning from restrictive settings and homelessness
- (5) Home maintenance (in some situation)
- (6) Costs of room and board while waiting for other assistance.

G. IN-HOME BEHAVIORAL TRAINING PROGRAM (DD)

1. MCCMH has recognized the need to offer more specialized and individualized treatment to persons with developmental disabilities within the natural environment for consumers with severe behavioral challenges that require consistent home-based interventions as an adjunct to or in place of agency or school-based services. In-home training can be briefer, less expensive, and offer the possibility of more extensive and longer lasting benefits than would traditional center-based services. With the completion of a training program the primary caregiver(s) will be able to assess and modify maladaptive behaviors based on the techniques used in the home by the training agency. These same techniques can also be used to teach and strengthen functional behavior and allow enhancement of residential independence.
2. The In-Home Behavioral Training Program maximizes support to the family and alleviates stress by reducing or modifying behavioral challenges to enable the family to function more effectively. Additionally, the potential for individual growth is enhanced as newly acquired, more acceptable behavior is learned that will enable the individual to interact more productively and adaptively within the community.
3. Services include: Psychiatric Evaluation, Psychological Assessment Testing, Initial Core Assessment, Behavioral Analysis, Medication Review, Medication /Administration, Individual, Group, or Family Therapy, Supports Coordination

III. MCCMH CORE PROGRAMS

A. CRISIS CENTER

1. PURPOSE

- a. Utilizing community resources and volunteer para-professionals, the

Macomb County Crisis Center provides an array of prevention services to promote healthy outcomes for persons who are or may be at risk.

- b. Given the nature of prevention, it is not feasible to determine the outcomes of this intervention using measurable results that are derived from rigorous scientific method. This is largely due to the fact that the Crisis Center 1) is working with free-willed human beings who are beset with countless variables that influence the onset and resolution of their problems in daily living, and 2) adheres to the belief that services should be delivered in a person-centered manner that is the least restrictive and intrusive to the consumer except in life and death situations. Consequently, services are designed in accordance with internationally tried-and-true models and best practices which are supported by the latest research and empiricism.

2. _____ OBJECTIVES

The Crisis Center activities are driven by the following meta-goals which are established to promote prevention by providing individuals with information and skills which enable them to create their own desired future:

- a. To heighten community awareness, understanding, and acceptance of mental health problems, and to educate the community to the mental health services available.
- b. To provide positive educational experiences in problem solving for individuals in crisis so that they may learn to handle future difficulties with an increased sense of personal competence.
- c. To offer appropriate referrals to other agencies for on-going assistance and advocate when service problems arise.
- d. To work cooperatively within Community Mental Health and other human service agencies within the community in order to maximize the opportunity for consumers to have their service needs met.

3. DESCRIPTION

- a. Crisis Center is a 24-hour crisis intervention service providing telephone counseling in a variety of areas, including emotional problems, suicide, domestic violence, substance abuse, sexual assault, family difficulties, and many other daily living problems.
- b. Crisis Center also functions as a major information and referral source within Macomb County. Crisis Center provides back-up and

coordinates communication to assure that recipients seeking services or experiencing crises during non-business hours are supported and protected. Back-up is provided for the Access Center and for other direct and contract provider services of MCCMH.

- c. The Crisis Center maintains an extensive and continually updated resource file with an emphasis on free and low cost human services.
- d. Community education programs are provided to schools and other professional organizations on the topics of suicide prevention and sexual assault.
- e. The Macomb Emergency Response Group (MERG) is another component of the Crisis Center which is designed to prevent, minimize, and help eliminate long-term stress reactions caused by various disasters or crisis situations that occur in the community. The Crisis Center also provides workshops and support groups for the friends and relatives of persons who have completed suicide.

4. SERVICES

- a. **Crisis Counseling and Intervention**
The Macomb County Crisis Center is a 24-hour crisis intervention telephone service which uses a skilled, interpersonal method of assisting individuals to restore their sense of equilibrium and prior level of functioning following a crisis event. Telephone counseling is provided in a variety of areas, including emotional problems, suicide, domestic violence, substance abuse, sexual assault, family difficulties, and many other daily living problems. The Crisis Center also utilizes a TDD (Telecommunications Device for the Deaf) to enable communication with deaf or hearing impaired people who have similar devices in their homes. The Center takes an active role in advocating for hearing-impaired persons who are seeking mental health services.
- b. **Information and Referral**
The Crisis Center functions as a major Information and Referral source within Macomb County. The Center maintains an extensive and continually updated resource file with an emphasis on free and low cost mental health related services. Private citizens, professionals, and school personnel rely on the Center for referral resources within rapidly changing service systems. When it becomes apparent that a needed service is not available, the Crisis Center participates with various local agencies in planning for new services and improving existing services.
- c. **Community Education**

Community Education Programs are provided to schools and other professional organizations on the topics of suicide prevention, sexual assault, the Crisis Center program, and MCCMH services. The Center also represents the MCCMH system at a variety of public information events.

d. Volunteer Program

Volunteer recruitment, training and supervision are integral parts of the agency's operation. Volunteers participate in about 52 hours of training prior to working on the crisis telephones. On-going supervision and additional training is provided throughout the volunteer's involvement with the center. Trained volunteers leaving the Crisis Center often continue to contribute to the community through the use of their counseling skills, and knowledge of community resources.

e. Macomb Emergency Response Group (MERG)

MERG was designed to prevent, minimize, and help remediate the stress reactions caused by various disasters or crisis situations that can occur in the community. It is a collaborative project which utilizes mental health practitioners, local clergy, and other professionals who are trained to respond to natural and man-made disasters. These could include suicide, homicide, home fires, industrial accidents, floods, tornadoes, or airplane crashes.

f. Survivors of Suicide

This is an eight-week workshop for friends and relatives of people who have completed suicide. The basic purpose of the Survivors of Suicide group is to facilitate the recovery or healing process by providing information, support, resources, and allowing the members to vent their feelings in a safe, accepting, and confidential setting.

5. ELIGIBILITY CRITERIA

None - Crisis Center services are available to all callers; TDD access is available.

B. ACCESS CENTER

1. PURPOSE

The MCCMH Access Center operates 24 hours per day, year round to provide service authorizations and managed care functions necessary for MCCMH to operate in a managed care environment.

2. OBJECTIVES

- a. To provide a welcoming, single-entry portal for Macomb County residents seeking services from the MCCMH service system.
- b. To assure that eligibility and level of care decisions are made promptly and uniformly in keeping with the level of urgency of the consumer's need.
- c. To assure that each consumer receives the right services in the right amount at the right time through authorization and/or monitoring of service provision on both individual and aggregate bases.

3. DESCRIPTION

The Access Center is available to all Michigan residents and is not restricted to individuals who live in a particular geographic region. It provides centralized initial screening to individuals seeking mental health and/or developmental disability services from MCCMH. The Access Center's telephone response system is answered by a live voice and demonstrates a welcoming, accepting and helpful atmosphere. All routine, urgent and emergent service requests are immediately answered or transferred to qualified practitioners (without requiring individuals to call back) who provide telephone triage, conduct a brief risk assessment, obtain general client/consumer information and provide referral/authorization for appropriate MCCMH services. The Access Center provides level of care approval and continued stay approval for all service providers to assure the delivery of appropriate MCCMH services. The Access Center provides clinical review of prior level of care denials (in response to provider requests.)

4. SERVICES

- a. Access Center Services have the capacity to complete the following functions:
 - (1) Determination of urgency - (according to established acute and chronic care protocols) of the patient's/consumer's current level of need for services (emergent, urgent or routine).
 - (2) Resolution - of immediate patient/consumer crisis through telephone crisis intervention and/or crisis counseling services as appropriate to the presenting situation.
 - (3) Initiation - determination of the consumer's eligibility for MCCMH funding for mental health, substance abuse or developmental disability services. All Macomb County residents may request services. The Access Center will determine service eligibility based upon the terms of the

Board's contract with MDCH, and the Michigan Mental Health Code requirements.

- (4) Approval - assessment and determination of the level of care needed by the consumer as appropriate to clinical criteria and medical necessity.
 - (5) Linkage - consumer is referred to a service provider to deliver the most appropriate face to face assessment and level of care.
 - (6) Coordination - information and coordination of care regarding non-MCCMH services (either public or private non-profit) that are appropriate to the consumer's current needs.
 - (7) Assistance - directing the consumer to a Membership Services representative staff on-site in the Access Center for resolution of questions regarding benefits.
- b. Access Center provides level of care approval and continued stay approval:
- (1) Approval for the initial face-to-face assessment and service planning;
 - (2) Approval for the initial admission to a level of care of MCCMH funded services;
 - (3) Approval for the continuation of a level of care or movement to another level of care;
 - (4) Care coordination and treatment monitoring to assure consumers are receiving services at the appropriate level of care at the appropriate time of need.
- c. The Access Center provides clinical review of prior level of care denials as follows:
- (1) Review of requests for reconsideration regarding denial of level of care admissions;
 - (2) Physician review and assessment of clinical criteria and medical necessity as a second level review for level of care determinations;
 - (3) Review of requests for retrospective (post-discharge) approval of MCCMH funding for services.

5. ELIGIBILITY CRITERIA

All Macomb County residents may request services. The Access Center will determine service eligibility based upon the terms of the Board's contract with MDCH, or any other purchaser of Board services, as relevant to the specific contract and service request.

C. HOSPITAL-BASED PROGRAMS

1. PURPOSE

MCCMH provides mental health services in community-based psychiatric inpatient units for Medicaid consumers who reside within the service area. Consumers may be admitted for inpatient psychiatric services, receive partial hospitalization services, receive referrals to alternative services when appropriate or available, or resolve a crisis through provision of immediate services / interventions, with follow-up as necessary.

2. OBJECTIVES

To provide effective treatment intervention that addresses the consumers' presenting signs and symptoms in the least restrictive, level of care.

3. DESCRIPTION

a. Hospital services include:

- (1) Emergency psychiatric services,
- (2) State inpatient psychiatric services,
- (3) Community-hospital inpatient psychiatric services, and
- (4) Community-hospital partial hospitalization (PHP) services.

b. The services listed above are authorized on a per diem basis for state and community hospitals for both adults and children. Specific services (e.g., Electro-Convulsive Therapy) are authorized separately in order to ensure close oversight of these services.

c. All consumers are assessed in a timely manner. Consumers are to be seen by a program physician within ninety (90) minutes of registration.

d. Consumers not needing acute care will be informed to contact the MCCMH Access Center for referral.

e. For individuals receiving Inpatient/PHP services, coordination with substance abuse treatment providers and referrals/linkage to alternative services are provided as appropriate. Coordination with treating and/or referring providers, as well as with the consumer's primary care physician or health plan, is also arranged.

4. SERVICES

- a. **Emergency Psychiatric Services**
Emergency psychiatric services are provided seven days a week, 24 hours per day, for adults and children/adolescents, by fully licensed and credentialed physicians in good standing. Besides the provision of comprehensive psychiatric evaluations to determine the suitability of patient admissions, emergency facility services are provided, including ambulance (in-county and out-of-county) or other transportation (e.g. taxi), lab work, and holding charges.
- b. **Community-Hospital Inpatient Psychiatric Services**
Inpatient services are available 24 hours a day, 7 days a week, each week of the year to consumers who have received authorization for voluntary or involuntary hospitalization. Full program services include, but are not limited to didactic groups, medication groups, occupational therapy, individual therapy, activities therapy, treatment planning, and family involvement. While inpatient, the individual will be seen daily by a psychiatrist and in accordance with the person's individual plan of service.
- c. **Community-Hospital Partial Hospitalization Services**
PHP services offers treatment by a multi-disciplinary team that works with the individual to meet his/her needs for up to five days a week, six hours a day. PHP is for both those who have been previously admitted to inpatient settings or for those who cannot be served in an inpatient environment. It is also for those patients who are ready for release from the inpatient environment but need more intensive help than is offered in an outpatient program. A full range of therapeutic modalities is carried out in PHP, including psychiatric evaluation, occupational and activity therapy, individual psychotherapy, group therapy and psych-educational groups. For persons living in Macomb County, transportation is available by appointment to and from the program daily.

5. ELIGIBILITY CRITERIA

MCCMH makes authorization and approval decisions according to Level of Care guidelines as established by the State and reflected in the Board's contract with the Michigan Department of Community Health (MDCH) and the MDCH Medicaid Provider Manual. Requests for admission for inpatient/partial hospitalization services, or requests for continued stay are made to the MCCMH Access Center. The Access Center review the request and makes a timely disposition, either approving or denying the request according to severity of illness and intensity of service criteria. Admission criteria utilized are as follows:

- a. The patient's primary problem and admitting diagnosis must be of a psychiatric nature. (If the primary presenting complaint is associated with substance-induced toxic conditions, a screening shall be done to determine if patient's condition meets previously published acute

care detoxification criteria.)

- b. Severity of Illness and Intensity of Service clinical criteria as set forth in the MDCH Medicaid Provider Manual are used for the pre-admission screening to determine whether alternative services to inpatient admissions are appropriate and available. Involuntary admissions shall fit the admission criteria specified in Section 401 of the Michigan Mental Health Code, and voluntary admissions shall fit the admission criteria specified in Section 401 of the Michigan Mental Health Code.

6. DISCHARGE CRITERIA

Discharge planning begins at the date of admission, and is conducted using a person-centered planning process. Hospital personnel consult with the MCCMH Access Managers, and Client Care Coordinators in the completion of discharge planning. Discharge will occur when the consumer's condition no longer requires psychiatric inpatient care. Discharge standards for those persons being discharged from a state institution include the provider treatment team being responsible for determining that placement is appropriate; the individual must not object to being released from the institution; and the provider must provide supports and services that enable the person to live successfully in the community.

D. HOSPITAL DIVERSION PROGRAMS

Hospital diversion services are administered by MCCMH for those who qualify for inpatient services but who can be served safely and effectively in an alternative (non-hospital) environment. These hospital diversion services include Crisis Residential Services and Intensive Crisis Stabilization Services.

1. CRISIS RESIDENTIAL SERVICES

a. PURPOSE

Crisis Residential Services are designed to treat individuals who qualify for psychiatric inpatient services but who can be treated in a community living facility (CLF). Crisis residential services provide a short-term alternative to inpatient psychiatric services for persons experiencing an acute psychiatric crisis when clinically indicated.

b. OBJECTIVES

Crisis Residential Services are delivered through a person-centered and recovery/resiliency-oriented approach with a goal toward resolving the immediate crisis, averting a psychiatric admission (or shortening the length of an inpatient stay) and improving the functioning level of the person receiving services to allow him or her to return to less intensive community living as soon as possible.

c. DESCRIPTION

Crisis residential services are provided in a MDCH-approved, licensed and certified setting with 24-hour staffing by trained mental health direct care workers. Crisis Residential Services provides safe and structured twenty-four care outside of the inpatient psychiatric ward to adults and children who meet the criteria for admission to psychiatric inpatient care or who are being considered for early discharge from the hospital if appropriate alternatives to the hospital care can be arranged.

d. SERVICES

- (1) Crisis Residential Services can be used instead of inpatient services for up to twenty-eight days and includes treatment groups, medication management, psychiatric supervision, therapeutic support services, and nursing services. A psychiatrist is scheduled for multiple visits per week and is "on call" 24 hours per day. For children's crisis residential services, nursing services are available through regular consultation and are provided on an individual basis according to the level of need of the child. Those who stay longer than fourteen days also receive case management services. The setting is not a locked setting, but consumers should not leave unless accompanied by staff.
- (2) Individuals who are admitted to the crisis residential services are provided opportunities to explore and learn more about crises, substance abuse, identity, values, choices and choice-making, recovery and recovery planning.
- (3) Services are delivered according to an individual plan based on an assessment of immediate need. The plan is developed within 48 hours of admission. If the individual has an assigned case manager, the case manager is involved in the treatment and in follow-up services. The plan contains:
 - Clearly stated goals and measurable objectives, derived from the assessment of immediate need, stated in terms of specific observable changes in behavior, skills attitudes, or circumstances, structured to resolve the crisis;
 - Identification of the activities designed to assist the individual to attain his/her goals;

- Discharge plans, the need for aftercare/follow-up services, and the role of, and identification of, the case manager;
 - For children, the child's needs in context with the family's needs; educational services must be considered and the plan developed in consultation with the school district staff.
- (4) For individuals whose length of stay in the crisis residential program exceeds 14 days, an interdisciplinary team (the consumer, parent or guardian, psychiatrist, case manager, and other relevant professionals) must develop a subsequent individual plan of service based on comprehensive assessments. (Peer support specialists may be part of the interdisciplinary team and can facilitate some of the activities based on their scope of practice, such as facilitating peer support groups, assisting in transitioning individuals to less intensive services, and by mentioning towards recovery.)

e. ELIGIBILITY CRITERIA

Crisis Residential Services may be provided to adults and children who meet MDCH-mandated psychiatric inpatient admission criteria, but who have symptoms and risk levels that permit them to be treated in alternative settings. Services are designed for persons with mental illness or with mental illness and another concomitant disorder, such as substance abuse or developmental disabilities. For persons with a concomitant disorder, the primary reason for service must be mental illness.

f. EXCLUSION CRITERIA

Crisis Residential Services may not be appropriate where:

- (1) The consumer presents such a high risk of harm to self or others that containment in a locked hospital ward is necessary to ensure safety.
- (2) The consumer needs continuous skilled medical services to manage a transition in psychiatric medication or to assist with the interaction between serious mental illness and a complicating physical illness (i.e., cannot be medically cleared).
- (3) The consumer is unwilling to participate in Crisis Residential Services instead of inpatient psychiatric hospitalization.
- (4) The consumer does not have a stable living environment in

the community and a reliable circle of support (family, friends) who can assist with daily needs that will provide a suitable discharge environment when crisis residential services are no longer medically necessary.

- (5) The consumer is a child with serious emotional disturbance in a Child Caring Institution (CCI).

g. DISCHARGE CRITERIA

This service is intended to be short-term. Consumers are discharged and return to the community once the immediate crisis situation has been resolved and stabilization has been achieved. The consumer will be admitted to another level of care if longer services are required at another level based on a re-evaluation of the individual.

2. INTENSIVE CRISIS STABILIZATION SERVICES

a. PURPOSE

The purpose of Intensive Crisis Stabilization Services is to enable consumers to preserve community resources and to reduce the stressors associated with an inpatient stay. Intensive Crisis Stabilization services seeks to avoid inpatient services for those who can be safely and effectively served in their own living environment with intensive team support.

b. OBJECTIVES

To reduce the initiation of inpatient hospitalization for individuals who can be maintained effectively in the community with intensive community-based services, and to reduce the length of stay of inpatient hospitalization for individuals who can be maintained effectively in the community with intensive community-based services.

c. DESCRIPTION

Intensive Crisis Stabilization Services (for adults, adolescents and children) is a combination of community-based treatment and supports, provided to consumers in crisis so that individuals at risk for immediate or continued inpatient psychiatric hospitalization can be served safely and effectively outside a hospital. Services will be provided primarily in the community by a treatment team made up of mental health professionals under the supervision of a psychiatrist, who has 24 hour availability. The treatment team may be assisted by trained paraprofessionals under appropriate supervision. In addition, the team may include one or more peer support specialists.

d. SERVICES

- (1) The Intensive Crisis Stabilization Team (ICST) is empowered to meet frequently (daily if necessary) with the consumer and includes:
 - psychiatric medication services,
 - intensive individual counseling/psychotherapy,
 - assessments,
 - psychiatric supervision,
 - nursing services,
 - therapeutic support services,
 - case management services, and
 - (abbreviated) person-centered planning.
- (2) The team may send out a team member to the hospital to evaluate the patient. The ICST can provide this level of service to consumers for up to twenty-eight days. The person is transitioned to community-based services provided through outpatient clinics as their need for intensive supports declines.
- (3) Intensive Crisis Stabilization Services may be provided where necessary to alleviate the crisis situation, and to permit the person to remain in, or return more quickly to, his/her usual community environment. This includes the consumer's home, the offices of the MCCMH Crisis Stabilization Program, and other community locations, as necessary to provide appropriate crisis services. (Intensive Crisis Stabilization Services cannot be provided in inpatient settings, jails, or Crisis Residential settings.)
- (4) Planning is focused on immediate and short-term actions and services necessary to manage the immediate crisis and stabilize the consumer's functioning so that transfer to an appropriate provider for continuing services can be facilitated. Planning must be completed within 48 hours of entering the program. Plan must contain clearly stated goals and measurable objectives, derived from the assessment of immediate need, and stated in terms of specific observable changes in behavior skills, attitudes, or circumstances structured to resolve the crisis. The plan for children in crisis stabilization services must consider the family context and the child's educational needs.

e. ELIGIBILITY CRITERIA

These services are for persons (adults, adolescents, children) who have been assessed to meet criteria for psychiatric hospital admissions but who, with intense interventions, can be stabilized and served in their usual community environments. These services may be used to avert a psychiatric admission, or may be provided to individuals leaving inpatient psychiatric services where the provision of such services will result in a shortened inpatient stay. Beneficiaries must have a diagnosis of mental illness or mental illness with a co-occurring substance use disorder or developmental disability.

f. **EXCLUSION CRITERIA**

The following individuals will not be considered for Intensive Crisis Stabilization Services:

- (1) Consumers who present such a high risk of harm to self or others that containment in a locked hospital ward is necessary to ensure safety.
- (2) Consumers who need continuous skilled medical services to manage a transition in psychiatric medication or to assist with the interaction between serious mental illness and a complicating physical illness.
- (3) Consumers who do not have a stable living environment in the community and a reliable circle of support (family, friends) who can assist with daily needs.
- (4) Children and adolescents are not excluded solely on the basis of their juvenile justice status if they otherwise meet eligibility criteria.

g. **DISCHARGE CRITERIA**

Consumers are discharged once the immediate crisis situation has been satisfactorily resolved and stabilization has been achieved. Plans for follow-up services (including other mental health services where indicated) are put in place after the crisis has been resolved.

E. RESIDENTIAL TREATMENT AND HOUSING PROGRAMS

Community-based services administered by MCCMH fall into several broad categories, each category being representative of the varying levels of care and support needed by the consumer, in accordance with an agreed upon individual plan of service. Residential services include active treatment services with living arrangements that support the individual. These services are provided in licensed Community Living Facilities, in Supported Independence Programs, and in subsidized apartments. (See also section I.H. herein, "Principles for Housing-

Related Services.”)

1. Community Living Facilities / Adult Foster Care Facilities

- a. Community Living Facilities are Adult Foster Care (AFC) homes specialized for the care of Adults with Serious Mental Illness or Adults with Developmental Disabilities. Services include Community Living Supports and Personal Care services provided up to 24-hours per day.
- b. Community Living Supports (CLS) are identified within the consumer’s individual plan of service goals and objectives and address the individual’s needs for community inclusion and participation. Goals are consistent with the consumer’s desired outcomes.
- c. Following an assessment of the consumer’s need, personal care services are authorized by a physician or the case manager or supports coordinator in accordance with an individual plan of service, and rendered by a qualified person. Personal care services include assistance with daily self care tasks that are beyond the level required by facility licensure such as:
 - Eating/feeding
 - Toileting
 - Bathing
 - Grooming
 - Dressing
 - Medication assistance
 - Ambulation
- d. Consumers with Supplemental Security Income or Social Security Disability Insurance contribute to the rent for the facility up to the limits approved by those funding sources.

2. Supported Independence Programs

- a. Supported Independence Programs provide less-than-twenty-four hour supports (as identified within the consumer’s individual plan of service goals) to individuals in housing units sub-leased from the CLS provider. Consumers with Supplemental Security Income or Social Security Disability Insurance contribute to the rent for the facility up to the limits approved by those funding sources.
- b. Consumers who are eligible are assisted with enrolling for housing supports from other sources (e.g., Homeless Assistance Recovery Program vouchers), which subsidize their rent up to a specific percentage of their income. Consumers usually share living space with one or two other consumers in order to afford the Fair Market

Rent of apartments and homes in the community. CLS provider staff are typically available within the apartment complexes in which the apartments are rented.

3. Project for Assistance in Transition From Homelessness (PATH) and Supportive Housing Program-Supportive Services Only (SHP-SSO) Programs

a. These programs combine aggressive outreach and interventions designed to meet the needs of individuals with mental illness who are homeless. Services include, but are not limited to:

- (1) Support in assessing income supports such as federal disability income or veteran benefits,
- (2) Assistance in locating affordable housing which may include financial assistance with damage/security deposit, first months rent and utility deposit assistance when needed,
- (3) Support in moving into a housing unit and in obtaining household furnishings and supplies, and
- (4) Linkage to appropriate medical, mental health and educational services.

4. Housing Resource Center (HRC)

a. The HRC will serve adults with serious mental illness who are seeking:

- (1) Information, training, and support regarding the process of finding and entering independent living arrangements in their own "place" (apartment or home);
- (2) Roommates with whom to establish independent living arrangements; and
- (3) Available, affordable, acceptable housing units in Macomb County.

b. The HRC will serve as a centralized housing support center providing a variety of services to MCCMH consumers. The HRC, as currently being implemented, will:

- (1) Collect and distribute information to MCCMH consumers about available housing options in Macomb county, both in properties directly linked to MCCMH and in the general housing marketplace (including a centralized registry of current vacancies):

- Centralized Available Housing Database – The creation of a centralized database that contains available housing options in Macomb County, including properties directly linked to MCCMH and the general housing marketplace. This function will be interconnected to the roommate program and the housing retention services.
- Website – The centralized housing support center will develop and maintain a Macomb County Housing Resource website. The website will serve as an effective tool in educating individuals in the community. The Macomb HRC will conduct the necessary research to bring valuable and accessible information and links to the website. Information contained on the website will include an updated Macomb housing directory, subsidized housing lists, databases that allow an individual to receive information on a variety of housing and/or service providers within the county.

(2) Provide training, support, and technical assistance to consumers about obtaining and maintaining appropriate housing (e.g., local zoning regulations, landlord-tenant issues, various housing subsidies, financing and foreclosure prevention, etc.):

- Educational Workshops – Interesting and informative workshops will be presented around the County to individuals with disabilities, family and support persons on a variety of housing topics such as: Understanding Section 8, Fair Housing, Home ownership, Landlord Tenant issues, Eviction Prevention.
- Technical Assistance – The centralized housing support center will specialized consultation services to individuals and their circles of support on issues including but not limited to: local zoning regulations, locating housing, fair housing, landlord tenant issues, acquisition, developing a budget, credit repair, foreclosure prevention, stabilization of independent housing, section 8, and other housing subsidies.

(3) Coordinate and disseminate information regarding potential roommates and arrangements for sharing the same residence, and assist with mediation of conflicts that threaten on-going stability in such arrangements,

- Roommate Program – Sharing costs of housing and supports is an effective mean to utilize resources. One of the major barriers is finding and retaining roommates. The centralized housing support center will develop and maintain a roommate database that will assist in the coordination and identification of potential roommates. The program will provide training and mediation in the retention of matches to ensure long term stability.
- (4) Facilitate peer support groups regarding housing issues for MCCMH consumers and their natural supports (e.g., families, friends):
- Support Groups – The centralized housing support center will facilitate an Independent Living Club (ILC) that will provide education to individuals on a wide range of issues related to living independently. Some of the topics covered include, but will not be limited to: money management, weatherization, fire safety, credit worthiness, and self advocacy. While the ILC will be facilitated by a staff member it will remain consumer driven, and participants will be encouraged to share advice and experiences with the group. In addition, facilitated a support groups for families of individuals who are working toward accessing safe and affordable housing will be needed. The centralized housing support center will have monthly meeting topics and idea sharing with families. Since education is the key focus, this venue is one in which will provide quality information to a large quantity of people at once.
- (5) Train and support peer advocates to assist with housing of MCCMH consumers,
- Peer Advocate Training Program – The centralized housing support center will interconnect work currently being conducted in coordination with MCCMH to implement and administer a training program designed to train consumers, families and supports on how to be a housing advocate. This program will heighten the awareness of housing issues in the county. Some of the trained peer advocates may work in conjunction with a Macomb centralized housing support center to assist other consumers with housing issues.

(6) Develop and maintain good working relationships with landlords and MCCMH-funded case management / support coordination providers.

- Landlord Outreach – The centralized housing support center will develop and maintain relationships with landlords. In addition, the centralized housing support center will act the primary housing contact for the landlords when issues arise and work with supports to ensure that the issues are addressed and housing is retained. The centralized housing support center will educate landlords about supportive housing issues including but not limited to disability awareness, fair housing issues, and accessibility.

c. The Coordinated Homeless Housing Resource Center is being implemented for persons who are chronically homeless. There are three primary activities: Coordination, Outreach and Recovery:

(1) Coordination - Synchronization of outreach and recovery efforts will require the involvement of an active Coordinated Interagency Service Team (CIST), which CHN will develop and oversee in partnership with MCCMHS. The team, initially comprised of representatives from at least ten collaborating agencies, will help expedite access to existing programs and services from their respective organizations. All coordinated services will address the emergency, short-term and long-term housing and supportive service needs of homeless persons entering the Coordinated Homeless Housing Resource Center.

(2) Outreach - CHN will develop and implement an intensive homeless outreach effort that will be flexible, mobile, and effective in establishing rapport with homeless persons with SMI and/or SA. By employing comprehensive county-wide outreach, the CHHRC will become one consistent, safe place for the homeless to be engaged. Some goals of outreach will be to:

- Engage homeless persons, establish a trust based relationship; and educate them about housing and available recovery opportunities;
- Further the outreach engagement process by providing critically needed items to enhance the development of a trust based relationship, such as snacks, personal hygiene items, and warm clothing;
- Adhere to a reliable outreach schedule of stops at

regular times and dates at multiple locations throughout the county;

- Provide immediate intake and assessment of short and longer-term needs for housing and support services;
- Obtain individual's consent to "enter" the CHHRC and to accept recovery services within the program;
- Rapidly attempt to secure permanent housing with appropriate supportive services and if permanent housing units are not available secure livable temporary housing and emergency services to sustain the individual until more permanent housing and longer term support services can be obtained. The CHHRC will participate with the local HMIS to track services and outcomes of homeless persons.

(3) Recovery – After a homeless person with SMI has been approached / contacted and is willing to accept services, the CHHRC will:

- Assist persons in securing affordable housing by utilizing existing housing resources in the county;
- Pilot new technology that will provide real time descriptive details about available housing vacancies throughout the county;
- Provide broad case management and follow-up services by connecting persons to needed treatment and supportive services through our Coordinated Interagency Service Team system of contacts;
- Initially provide assistance with obtaining birth certificates, social cards and other important documents so they be prepared to access housing and follow- up support services;
- Provide each CHHRC participant with an organizational binder where important documents can be kept, and that contains contact information for 24 hour local emergency resources;
- Provide immediate and short-term housing related case management. Such case management will include the establishment of an educational process that will help our consumers and their landlords

improve relations with each other.

F. ASSERTIVE COMMUNITY TREATMENT PROGRAM

1. PURPOSE

Assertive Community Treatment (ACT) is a structured team-based approach designed to support consumers with serious mental health illness in the community rather than in hospitals or specialized residential settings (CLF's, SIPs). It is identified as an Evidence-Based Practice and incorporates specific core elements. In addition, the program strives to enable members to learn to identify and recognize the early indicators of increased symptoms and to assist them in knowing how to voluntarily seek appropriate, even preventative, interventions. ACT is designed to enhance the overall quality of life for its members and to aid in the process of the consumer's recovery as it increases stable patterns of independent community living. The ACT team provides a fixed point of responsibility for the development of the individual plan of service using the person-centered planning process, and for supporting consumers in all aspects of community living. Other disciplines and/or referrals to other supportive services as appropriate can be involved as appropriate.

2. OBJECTIVES

- a. To reduce the number of psychiatric hospitalizations for program members.
- b. To reduce the length of stay for necessary hospitalizations and increase the length of time between hospitalizations (time in community).
- c. To assist members in improving the overall quality of their lives as demonstrated by increasingly stable patterns of community living, relationships, and self-satisfaction.

3. DESCRIPTION

The ACT program serves consumers with serious mental illness and co-occurring disorders who, without ACT, would require more restrictive services and/or settings. The settings for the provision of services are according to the consumer's preference and clinical appropriateness; at least 80% of services are provided in the consumer's home or other community locations. The ACT team is the fixed point of responsibility for all services for the members associated with it, including psychiatric services, IDDT interventions, nursing services, case management services, treatment services, housing support services, etc. Contacts between the consumer and ACT team members occur at least several times each week. ACT team members are available to assist consumers with crises and emergencies on a 24/7 basis. Case management services are interwoven

with treatment and rehabilitative services, and are provided by all members of the team. Consumers are assisted in accessing needed physical health care (including dental services), financial assistance, housing, employment, education, social services, and other services and natural supports that are identified through the on-going person-centered planning process. ACT team members identify and address gaps in services.

4. SERVICES

ACT teams provide an array of clinical, medical, or rehabilitative services during face-to-face interactions that are designed to help consumers to live independently or facilitate the movement of consumers from dependent settings to independent living. Case management services are interwoven with treatment, rehabilitation and recovery services, providing the linkage, coordination and support as necessary. The focus is on maximizing the consumer's independence and quality of life, such as maintaining employment, social relationships and community inclusion. Services are consistent with consumer preferences, following professionally accepted standards of care, and are medically necessary. Services include but are not limited to:

a. Diagnostic services that may include the following:

- Core Assessment
- Psychiatric Evaluation
- Family Assessment
- Psychological Assessment/Testing
- Health Assessment

b. Therapeutic services that may include the following:

- Person Centered Planning
- Medication Review
- Medication Administration
- Individual, Group, or Family Therapy
- Crisis Intervention - ACT team members are available on a 24/7 'on-call' basis shared by team members.
- Assertive Community Treatment Contacts

5. ELIGIBILITY CRITERIA

ACT serves consumers with serious mental illness and co-occurring disorders who have a history of multiple psychiatric hospitalizations and may be at risk for on-going inpatient hospitalization, intensive crisis residential or partial hospitalization services, detoxification and rehabilitative admissions, but can remain safely in their communities with the considerable support and intensive interventions of ACT. Please see the MDCH Medicaid Provider Manual for the diagnosis, severity of illness, and intensity of service eligibility criteria for ACT services.

6. DISCHARGE / TRANSFER CRITERIA

- a. The consumer's recovery process has led to the re-establishment of major role functions for a period of time that demonstrate stability in functioning that may be maintained without the support of ACT-specific services.
- b. The consumer requests transition to other service(s) for which the consumer has been authorized.
- c. The consumer moves outside of the geographic service area.
- d. A transition plan identifying the supports and services available in other service settings/ programs has been established through a person-centered planning process. ACT contacts continue until services has been established in a new location or program.
- e. The consumer has chosen to discontinue participation in ACT services.
- f. If a consumer demonstrates behavior determined to be a safety concern that cannot be managed in the ACT program, the clinician / case manager is responsible for follow-up to determine whether the consumer will need further services, and shall offer or refer the consumer to needed services when possible. Follow-up shall occur within within seventy-two (72) hours to ensure linkage to appropriate care.

G. INTEGRATED DUAL DISORDER TREATMENT (IDDT) PROGRAMS

1. PURPOSE

Integrated Dual Disorder Treatment (IDDT) is a structured team-based approach that is identified as an evidence-based practice by SAMHSA. It is one form of integrated services for persons with serious mental illness who have co-occurring substance use disorders. Fidelity to the IDDT treatment requires that services for substance use disorders be delivered simultaneously with services for serious mental illness and that all services be matched to each individual's stage of change regarding the substance use or the mental illness. It also requires that substance use disorder (SUD) treatment services (both individual and group) be available through the IDDT team.

2. OBJECTIVES

- a. To improve the quality of life for persons with dual disorders by integrating substance abuse services with mental health services;

- b. To utilize biopsychosocial treatments (combine pharmacological, psychological, education, and social interventions) to address the needs of consumers and their care givers (family and friends);
- c. To promote improved functioning, such as the development of:
 - (1) meaningful relationships,
 - (2) stable, secure housing, and
 - (3) employment or meaningful activity.

3. DESCRIPTION

The IDDT evidence-based practice by SAMHSA shares some of the key elements described for the Assertive Community Treatment but can be delivered by treatment teams that are not identified as ACT teams. The treatment teams also assist consumers with finding and entering substance use peer support groups that are prepared to assist with co-occurring mental health and substance use disorders. IDDT team members are expected to be welcoming to persons with co-occurring disorders and to reach out to engage them in treatment. Psychiatric services and medication are provided regardless of the level of substance use/abuse that may be occurring simultaneously.

4. SERVICES

- a. Services are delivered through a multi-disciplinary team that includes substance abuse specialist who works collaboratively with the treatment team, attends all team meetings, and is involved in treatment planning;
- b. Interventions are consistent with each stage of the consumer's recovery (engagement, motivation, action, relapse prevention);
- d. IDDT consumers have access to the following comprehensive DD services:
 - Residential services
 - Supported employment
 - Family psycho-education
 - Illness management
 - ACT or ICM
- e. Consumers have access to the following time-unlimited services, with intensity modified according to each consumer's needs:
 - Substance abuse counseling
 - Residential services
 - Supported employment

- Family psycho-education
 - Illness management
 - ACT or ICM
- f. Outreach and strategies such as housing assistance, medical care, crisis management and legal aid, are used whenever appropriate;
- g. Motivational interviewing interventions, such as expressing empathy, avoiding argumentation, rolling with resistance, and instilling self-efficacy and hope, are implemented by IDDT staff;
- h. Consumers who are in the action stage or relapse prevention stage receive substance abuse counseling that include:
- Teaching how to manage cues to use and consequences to use;
 - Teaching relapse prevention strategies;
 - Drug and alcohol refusal skills training;
 - Problem-solving skills training to avoid high-risk situations
 - Coping skills and social skills training
 - Challenging consumers' beliefs about substance abuse.
- i. Clinicians provide family members family psycho-education:
- Education about DD
 - Coping skills training;
 - Collaboration with the treatment team;
 - Support.
- j. Consumers in the action stage or relapse prevention stage attend self-help programs in the community;
- k. Prescribing practitioners:
- Prescribe psychiatric medications despite active substance use;
 - Work closely with team/consumer;
 - Focus on increasing adherence;
 - Avoid addictive substances.
- l. Interventions are used that promote health, including:
- Teaching how to avoid infectious diseases,
 - Helping consumers avoid high-risk situations and victimization,
 - Securing safe housing,
 - Encouraging consumers to pursue work, medical care, diet, and exercise.

- m. The IDDT program has a protocol for identifying substance abuse treatment non-responders and offers individualized secondary interventions, such as:
 - Medications (clozapine, naltrexone, disulfiram)
 - Long-term residential care
 - Trauma treatment
 - Intensive family intervention
 - Intensive monitoring.

5. ELIGIBILITY CRITERIA

Persons with serious mental illness who have co-occurring substance use disorders are eligible to receive IDDT services.

6. EXCLUSION CRITERIA

- a. The consumer with serious mental illness and co-occurring substance use disorder can be served effectively in a “dual-disorder enhanced” mental health treatment program that does not include all the elements associated with the IDDT model (e.g., is not team-based).
- b. The consumer with serious mental illness and co-occurring substance use disorder chooses another form of integrated co-occurring treatment services.

7. DISCHARGE / TRANSFER CRITERIA

- a. The consumer’s recovery process has led to the re-establishment of major role functions for a period of time that demonstrate stability in functioning without support of ACT-specific services.
- b. The consumer requests transition to other service(s).
- c. The consumer moves outside of the geographic service area.
- d. A transition plan identifying the supports and services available in other service settings/ programs has been established through a person-centered planning process. ACT contacts continue until services has been established in a new location or program.

H. CASE MANAGEMENT / SUPPORT COORDINATION PROGRAMS

1. PURPOSE

- a. Adults with serious mental illness or children with serious emotional

disturbances can experience substantial functional limitations in two or more significant life domains (e.g., self-care, self-direction, income management, social relationships) due to the serious mental illness or serious emotional disturbance. Case management services assists consumers who have multiple service needs and who are likely to have difficulty accessing and sustaining needed services on their own. Case management services assist in designing, accessing, and implementing strategies to build and maintain self-sufficiency and independent healthy roles in their own community.

- b. Persons with developmental disabilities have individual strengths and perspectives. These strengths and perspectives are maximized when they are as integrated into the community and as independently functioning as possible. Case management for persons with developmental disabilities assists with the development, implementation, and nurturance of the supports needed for the persons served to become independent, self-sufficient, and integrated into the community.

2. OBJECTIVES

- a. To provide service coordination to consumers in order to advocate for the consumers and link them with necessary resources to meet their needs.
- b. To assist consumers in managing one or more areas of daily functioning.
- c. For adults with serious mental illness or children with serious emotional disturbances, to support consumers in developing understanding of skills in managing symptoms and challenges associated with chronic mental illness.
- d. To support consumers in optimizing independence, self-sufficiency, and inclusion into the community.
- e. To enable persons served to increase their independence in a number of living skills, including management of self medication, money management, meal planning and preparation, vocational skills, grooming and hygiene, and household maintenance skills.

3. DESCRIPTION

- a. Targeted Case Management services for persons with Serious Mental Illness, or Support Coordination Services for persons with Developmental Disabilities, are for individuals who need assistance and support in accessing health care and other services. Case management and Support Coordination services assist in obtaining resources and supports to sustain the recovery process from serious mental illness. Supports coordinators and case managers organize

and oversee the Person-Centered Planning Process.

- b. Services include providing assistance to consumers in planning, obtaining, and using individualized, goal-oriented services and supports from MCCMH, from other public service organizations, and from general community resources. Consumers are assisted in accessing needed physical health care (including dental services), financial assistance, housing, employment, education, social services, and other services and natural supports that are identified through the on-going person-centered planning process. Case managers assist with assessment, planning, linkage, advocacy, and coordination of services. Case managers help to identify and address gaps in services and to manage transitions between services. Case managers are available on both a routine and emergency basis.

4. ELIGIBILITY CRITERIA

Individuals eligible are children with serious emotional disturbance, adults with mental illness, or persons with a developmental disability, who have substantial limitations in several functional domains and are unable to independently access and sustain involvement with services. The determination of the need for case management / support coordination must be documented in the consumer's record.

5. EXCLUSION CRITERIA

- a. Consumers have medically complex conditions that require continuous skilled nursing assistance.
- b. Harm or danger to self or others is an imminent risk and requires treatment in a higher level of care.
- c. The consumer has been incarcerated and is likely to remain so for an extended period of time. However, children and adolescents can not be excluded solely on the basis of their juvenile justice status.

6. TRANSFER / DISCHARGE CRITERIA

- a. Current case management goals have been met and there is no need for new case management goals. The consumer has community resources and natural supports which ensure safe, independent living in the community.
- b. For consumers with serious mental illness:
 - (1) The consumer has not been hospitalized or required intense crisis care other than for episodic brief contacts that are short in duration, and that have become less serious over time. The frequency of these contacts for emergency care have lessened and the consumer is able to more quickly

return to their previous level of functioning.

- (2) The consumer has demonstrated the skills to maintain him/herself in the community. This includes being able to access and utilize resources for: medication, food, transportation, medical care, entitlements, funding, and emergency care. The consumer is able to accomplish these goals with decreasing support from MCCMH staff.

c. For consumers with developmental disabilities:

- (1) The consumer no longer experiences substantial limitations in three of the following seven areas that are identified in the Federal definition of developmental disability: learning, receptive/ expressive language, personal hygiene/self care (ADLs), instrumental activities of daily living (e.g., shopping, cooking, laundry, home care), self direction/decision making, mobility, or economic self-sufficiency.

d. The consumer or his/her guardian request discontinuation of case management / support coordination services.

I. OUTPATIENT CLINIC PROGRAMS

1. PURPOSE

Therapy services are designed to reduce symptoms that disrupt personal experience, day-to-day functioning, and personal relationships; to improve skills in behavioral self control; and/or to restore normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the consumer, family and/or significant other to function more effectively.

2. OBJECTIVES

- a. To provide mental health treatment services to consumers in order for the consumer to successfully deal with the challenges associated with a serious mental illness, developmental disability, or serious emotional disturbance.
- b. To provide support services to families and significant others who are in a relationship with a person who is diagnosed with a serious mental illness, developmental disability, or severe emotional disturbance.
- c. To reduce symptoms of serious mental illness or serious emotional disturbance and to improve behavioral self-control.
- d. To improve daily functioning.

- e. To improve social relationships and strengthen natural support systems.

3. DESCRIPTION

Therapy services include face-to-face interactions between consumers and appropriately trained and credentialed mental health professionals for the purpose of reducing painful or intrusive symptoms and improving overall functioning. Outpatient therapy services take place on a scheduled, intermittent basis in clinic offices or community settings. Interventions can include the consumer's family, significant other, parent, or natural support systems as appropriate to reach the goals established through the person-centered planning process.

4. SERVICES

- Mental Health Assessment(s)
- Person Centered Planning
- Medication Review and Medication Administration
- Medication Training and Support
- Individual, Group, or Family Therapy
- Crisis Intervention

5. ELIGIBILITY CRITERIA

- a. The consumer presents with signs and symptoms consistent with serious mental illness (adults) or serious emotional disturbance (children) that require psychiatric medication or face-to-face psychotherapy.
- b. The consumer, his family, or his support system, can participate actively in interactions with the physician, nurse, or psychotherapist providing the interventions.
- c. The consumer, his family, or his support is willing and able to actively engage in self-description and self-disclosure appropriate to the level of therapy that is to be provided.

6. EXCLUSION CRITERIA

- a. The consumer is not a resident of Macomb county.
- b. The consumer meets MCCMH criteria for inpatient mental health treatment or an inpatient diversion service.
- c. The consumer does not meet Michigan Mental Code Criteria for Service.

- d. The consumer is incarcerated and is likely to remain so. Children and adolescents are not excluded solely on the basis of their juvenile justice status if they otherwise meet eligibility criteria.

7. DISCHARGE CRITERIA

- a. The consumer has met the therapy goals on the person-centered plan and there are no new therapeutic goals at this time.
- b. The consumer had not met the therapy goals on the individual plan of service and no further progress is likely at this time.
- c. The consumer moves out of Macomb County.
- d. The consumer withdraws from treatment.

8. TRANSFER CRITERIA

- a. The consumer is enrolled with a Medicaid Health Plan and his/her on-going mental health treatment goals can be addressed in twenty face-to-face sessions per year or less.
- b. The consumer wants to receive services from another provider. For example, the consumer wants to transfer to a community psychiatrist, a Primary Care Physician or a Medicaid QHP.
- c. The consumer has been assisted in preparing for the transition from one treatment setting to another. This means that the consumer 1) knows the time, date, and location of his or her next treatment or support service; 2) knows the method of transportation that will be available to attend the appointment; 3) knows what materials he or she is to bring to the next appointment; and 4) knows how to request changes in these plans if necessary (e.g., if his/her situations becomes urgent and the appointment needs to be arranged sooner than originally scheduled).
- d. In the case of transfer to another MCCMH panel provider, the consumer 1) has been approved for transfer by the MCCMH Access Center, and 2) has received an appropriate "tracking number" from Access Center to assist with monitoring the transition.

J. IN-HOME TREATMENT PROGRAMS

1. PURPOSE

Home-based treatment services are designed to assist children (birth through age 17) with serious emotional disturbance and their families, who require access to an array of mental health services. Services are delivered in the family residence several times a week. Services are delivered in a

manner sensitive to the developmental needs of the child.

2. OBJECTIVES

The goals of mental health home-based service programs are to:

- Promote normal development.
- Promote healthy family functioning.
- Support and preserve families.
- Reunite families that have been separated.
- Reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings.

3. DESCRIPTION

Home-based treatment utilizes a strength-based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with other service providers. The intensity of services depends on the needs of the youth and their families, and can range from two to twenty hours a week. The home-based services programs provided by MCCMH are approved by Michigan Department of Community Health.

4. SERVICES

Services include psychiatric services, family and individual therapy, behavioral training and intervention, and case management services.

5. ELIGIBILITY

Please see the MDCH Medicaid Provider Manual for the criteria for home-based services for children birth through three years, children age four through age six, and children ages seven to seventeen years.

6. EXCLUSION CRITERIA

- a. The consumer meets medical necessity criteria for higher levels of care (e.g., inpatient hospitalization)
- b. The family home is no longer safe for the consumer and his/her family.
- c. The consumer is in out-of-home placement.

7. DISCHARGE CRITERIA

- a. The consumer enters out-of-home placement.
- b. The goals of in-home services have been achieved and there are no new goals that can be served through the in-home program.

- c. The consumer no longer needs the bundled services delivered through the in-home program and can be transferred to other treatment settings (e.g., an outpatient clinic).

K. CLUBHOUSE PROGRAMS

1. PURPOSE

Psycho-social Rehabilitation is a State-approved program for adults with serious and persistent mental illness that allows for activities that develop, encourage, and sustain daily behaviors of consumers to achieve self-care, community living, social engagement, meaningful activity or employment, and independence. Activities may be facilitated by staff or consumers and shared among groups of participants. It provides both formal and informal structures through which members control their own participation and involvement in a clubhouse community. Through the structure of the work ordered day, the member develops skills that lead to involvement in activities he/she would otherwise not have tried. This “risk taking” is the basis for the continued growth that is part of the ongoing development of an adult who is participating in the surrounding world. The Clubhouse program has also been identified as an evidence-based practice (EBP) by SAMHSA.

2. OBJECTIVES

The major objective of Crossroads Clubhouse is to intervene in the lives of members in a way which empowers them to re-mediate functional deficits and (re)develop the abilities to live, learn, work, and socialize. Other major objectives include:

- To provide an environment conducive to the development of a community among the membership;
- To encourage the (re)development of adult roles by each member;
- To provide opportunities to (re)develop skills in living, learning, working and socializing;
- To empower each member toward self determination in all aspects of their lives, and in all aspects of the Clubhouse; and
- To reduce the use of inpatient psychiatric hospitalization among the membership.

3. DESCRIPTION

Crossroads Clubhouse utilizes the talents of members and staff together complete day-today operational tasks. All operations of the clubhouse are divided into units and committees who are, as a whole, responsible for assuring those operations are carried out. This includes food service,, maintenance and repairs, clerical, member services, governance, social/recreational opportunities, etc. The service record of a member is a

joint responsibility between the member and the unit leader. Decisions are made through a process of community meetings with an advisory group (open to all members) making recommendations. The clubhouse has a commitment to include members in community-based opportunities through their social/recreational components as well as their vocational components. Transitional Employment Positions are competitive, part-time positions in which any member of a clubhouse may serve. These positions may last as long as six months, before the position is then filled by another member. These positions, and the security of the clubhouse involvement, enable members to work in a competitive position and develop skills and stamina necessary for other employment objectives. The clubhouses maintains a close working relationship with the Michigan Jobs Commission to assist members in receiving services to gain permanent employment opportunities.

4. SERVICES

- Diagnostic: Psychosocial Rehabilitation Assessment
- Service Planning
- Therapeutic Psychosocial Rehabilitation
- Other: Vocational Services, Social/Recreational Services, and Transportation

5. ELIGIBILITY CRITERIA

- a. The consumer is an adult with serious mental illness who does not need inpatient care.
- b. The consumer has visited the program, has learned about the “work-ordered’ day and is willing to participate in at least one of the work units that complete the tasks necessary for the everyday functioning of the clubhouse.

6. EXCLUSION CRITERIA

- a. Consumers have no history of serious mental illness.
- b. Consumers are not willing to participate in Clubhouse activities.
- c. The consumer presents a risk to other members of the Clubhouse.

7. TRANSFER / DISCHARGE CRITERIA

- a. The consumer has indicated that he/she no longer wants to be a member of the clubhouse.
- b. In the case of transfer to another MCCMH program or provider, the consumer has been described to MCCMH program staff who can provide appropriate treatment in the future; has been approved for

transfer by the MCCMH Access Center; and has received an appropriate “tracking number” from Access Center to assist with monitoring the transition.

- c. In the case of transfer to another MCCMH program or provider, the consumer has been assisted in preparing for the transition from one program to another. This means that the consumer 1) knows the time, date, and location of his or her next treatment or support service with MCCMH staff or contractors; 2) knows the method of transportation that will be available to attend the appointment; 3) knows what materials he or she is to bring to the next appointment; and 4) knows how to request changes in these plans if necessary (e.g., if his/her situation becomes urgent and the appointment needs to be arranged sooner than originally scheduled).

L. CONSUMER-OPERATED PROGRAMS

1. PURPOSE

Consumer-operated programs and services empower consumers in the process of recovery from serious mental illness and in the development of resiliency and a self-determined life.

2. OBJECTIVE

Consumer-Operated Drop-In Centers provide an informal, supportive environment to assist consumers with mental illness in the recovery process. Drop-In Centers aim to provide opportunities to learn and share coping skills and strategies; to move into more active assistance and away from passive roles and identities, and to build and/or enhance self-esteem and self-confidence.

3. DESCRIPTION

Consumer-Operated Drop-In Centers are DCH-approved programs . The program’s staff and board of directors are primary consumers. Consumers have autonomy and independence in making day-to-day decisions, including financial ones, about the program. The drop-in center is located at a non-MCCMH site, and has obtained 501(c)(3) non-profit status. Where the service is identified in the consumer’s plan of service, it must state that it is medically necessary, must identify goals and how the program support those goals, and must identify the amount, scope and duration of the services to be delivered.

4. SERVICES

- a. The Drop-In Center provides social support and opportunities for social activities to its members. This includes evening, weekend, and holiday events.

- b. The Drop-In Center hosts peers and staff associated with MCCMH Housing support programs (see section III.E., above), Social Security enrollment programs, and similar projects.

5. ELIGIBILITY CRITERIA

- a. The consumer is a person with serious mental illness,
- b. The consumer is a resident of Macomb County.

6. EXCLUSION CRITERIA

The person is dangerous to others at the Drop-in Center.

7. TRANSFER / DISCHARGE CRITERIA

The person moves out of Macomb County.

IV. SPECIALIZED PROGRAMS FOR CHILDREN

A. INFANT MENTAL HEALTH PROGRAM

1. PURPOSE

Home-based Infant Mental Health Services are designed to serve mothers with infants at risk for development of emotional disturbance due to risk factors associated with socio-economic status, education, intelligence, and illness in either mother or infant.

2. OBJECTIVES

- a. To provide comprehensive and intensive mental health services to children and their families within their home environment thereby reducing or eliminating the need for out-of-home care and treatment.
- b. To provide mental health treatment and support services to the identified child improving the child's ability to function normally within his/her family.

3. DESCRIPTION

Infant Mental Health services provides intensive services to families, parents, and children who have multiple service needs and access to an array of mental health services and supports. The program is designed to promote child development and healthy family functioning and prevent the need (or reduce the use of) inpatient psychiatric services. Services are

delivered using a strength-based model, assertive intervention style, and partnership with parents. Services are delivered by one worker in the home and community.

4. SERVICES

a. Diagnostic services may include the following:

- Psychiatric Evaluation
- Family Assessment

b. Therapeutic services may include the following:

- Medication Review
- Medication Administration
- Individual, Group, or Family Therapy
- Crisis Intervention

5. ELIGIBILITY CRITERIA

a. Substantial limitations in two major life areas, as demonstrated by the following indicators and assessed on approved standardized instruments, such as the Bayley Scales of Infant Care and Development;

b. Recurring behaviors or expressiveness indicating affect/modulation problems, e.g., uncontrollable crying or screaming, sleeping and eating disturbances and recklessness; the absence of developmentally expectable affect, such as pleasure, displeasure, joy, anger, fear, curiosity; apathy toward environment and caregiver;

c. Distinct behavioral patterns coupled with sensory, sensory motor, or organizational processing difficulty (homeostasis concerns) that inhibits the child's daily adaptation and interaction/relationships. For example, a restricted range of exploration and assertiveness, dislike for changes in routine, and/or a tendency to be frightened and clinging in new situations, coupled with over-reactivity to loud noises or bright lights, inadequate visual-spatial processing ability, etc.;

d. Incapacity to obtain critical nurturing (often in the context of attachment separation concerns), as determined through the assessment of child, caregiver and environmental characteristics. For example, the infant shows a lack of motor skills and/or language expressiveness, appears diffuse, unfocused and undifferentiated, expresses anger/obstinacy and whines, in the presence of a caregiver who often interferes with the infant's goals and desires, dominates the infant through over control, does not reciprocate to the child's gestures, and/or whose anger, depression or anxiety results in inconsistent parenting.

6. EXCLUSION CRITERIA

Children who are no longer infants / toddlers and who are not a member of a family served by this program will be excluded.

7. TRANSFER / DISCHARGE CRITERIA

Children who need continuing care after they age out of infant mental health services will be referred to MCCMH for specialty mental health services and supports if they qualify for coverage under public funds.

B. CHILD CARE EXPULSION PROGRAM

1. PURPOSE

The Child Care Expulsion Program (CCEP) is a primary prevention program designed to stop the exclusion of children from child day care environment because of problematic behaviors.

2. OBJECTIVES

- a. To provide consultation to families and to day care providers regarding problematic behavior in particular children, with guidance regarding effective behavior change strategies.
- b. To provide consultation to day care providers regarding the structure and processes of the day care organizations so that the structures and processes can be modified to have optimal effect for all the children receiving day care in that setting.
- c. To provide training for day care providers and their staff regarding child development, behavior change strategies, and other topics as needed by the care child providers to improve services.

3. DESCRIPTION

The CCEP employs consultants who provide technical assistance to families and to the providers of day care services. First, CCEP consultants provide training for child care providers and their staff on issues of child development and behavior change in children. Second, CCEP staff provide consultation regarding individual children whose behavior places them at risk for expulsion from child care settings so that expulsion is not necessary. Third, CCEP staff will provide consultation regarding organizational issues in child care settings that may affect many children simultaneously and contribute to tensions between children, families and providers. Children and families who may need speciality mental health services and supports are referred to MCCMH for clinical follow-up. CCEP consultation involves data gathering by the CCEP staff regarding individual children whose behavior is problematic to others and about the structure and organization of child care settings, followed by suggestions to day care providers and to families about changes that will reduce such problematic behavior. CCEP training involves organized workshops by the CCEP staff regarding child

development and behavior change processes.

4. ELIGIBILITY CRITERIA

- a. Children must be receiving child care in licensed and unlicensed child care settings.
- b. Children whose behavior is problematic for parents or child care providers are the focus of individualized consultation.

5. EXCLUSION CRITERIA

- a. Children who are experiencing behavioral difficulties because of serious emotional disturbances are referred for speciality mental health services and supports to MCCMH or to other mental health providers in the community.
- b. Children who no longer use child care in licensed child care settings.

6. TRANSFER/ DISCHARGE CRITERIA

Children whose problematic behavior lead to a CCEP consultation will be discharged from CCEP oversight and follow-up after several months of improved behavior and reduced conflict with parents and child care providers.

C. EARLY-ON MACOMB PROJECT

1. PURPOSE

Pursuant to the federal Individuals with Disabilities Education Act and under the auspices of the Macomb County Human Services Coordinating Body, MCCMH provides service coordination and needed mental health services to qualifying families for the purpose of assuring that the children receive coordinated medical, educational and mental health services and that stress-related disabilities among family members are minimized.

2. OBJECTIVES

- a. To provide service coordination (i.e., case management) to families in order to link, monitor and advocate for the necessary range of medical, educational and mental health services to meet the individual child and family's needs.
- b. To arrange mental health treatment and support services including respite and special sitter services for the identified child's family in order to support the family's capacity to cope successfully with the demands of a chronically ill or disabled child.

3. DESCRIPTION

In partnership with community partners led by the Macomb Intermediate School District (MISD), MCCMH provides case management services for children admitted into the Early-On project.

4. SERVICES

Case Management Services

5. ELIGIBILITY CRITERIA

- a. Family/child must be enrolled in the Early-On Macomb Project through the MISD.
- b. Child is between the ages of 0 - 3.
- c. Child must be chronically ill or identified as a person with disability.

6. EXCLUSION CRITERIA

- a. Child is over the age range served by the Early-On program.
- b. Child is showing development within the average range.

7. TRANSFER / DISCHARGE CRITERIA

- a. Child ages out of the program.
- b. Child moves out of Macomb County.
- c. Child is no longer considered eligible for the program by the Macomb ISD.

D. SCHOOL BASED PROGRAM

1. PURPOSE

The Intensive Stabilization and Transition Program (CST) establishes a mechanism by which children with Serious Emotional Disturbance (SED) who are students in the Macomb Intermediate School District center-based programs can be served in the school setting as the student and his/her family are welcomed into services provided through MCCMH service sites. This program prioritizes students and their families who would be difficult to engage directly in MCCMH services without such transition services in the school setting.

2. OBJECTIVES

- a. To assist MISD students and their families through mental health assessment, therapy, and appropriate referral to improve their

overall functioning;

- b. To transition MISD students and their families to specialty mental health services and supports provided by MCCMH through MCCMH clinics;
- c. To support parents and family members of MISD students who are experiencing mental health difficulties.

3. DESCRIPTION

This program results from a cooperative working agreement between Macomb County Community Mental Health and the Macomb Intermediate School. The program is designed to ensure that children with serious emotional disturbance attending the ISD schools and their families may enter mental health services and supports offered by MCCMH as needed. A MCCMH therapist contracted by MISD from MCCMH is stationed in four MISD schools up to twenty-hours per week. The MCCMH IST therapist provides mental health services designed to stabilize immediate symptoms and to facilitate the transition of the student and her/his family to services delivered by MCCMH through its programs outside the school. The IST therapist is also be available to assist with MISD-MCCMH Parent Group(s), which are open to all parents of children/adolescents who are students in the MISD center-based programs. The MCCMH IST therapist is available for consultation and assistance with mental health crises in the schools.

4. SERVICES

Besides "Core Services," (assessment(s); individual, group or family therapy), crisis intervention and parent prevention groups may be provided.

5. ELIGIBILITY CRITERIA

- a. Students in this program will meet eligibility criteria for services as a Child with Serious Emotional Disturbance.
- b. Students and their families may become eligible for the full range of MCCMH services (e.g., inpatient hospitalization, crisis residential services, psychiatric evaluation and medication management, mental health case management, enhanced health services) as they become medically necessary and clinically appropriate.

6. EXCLUSION CRITERIA

- a. This program is restricted to children who are students at the Macomb Intermediate School District and to their families.
- b. This program is designed for children who show symptoms of serious emotional disturbance.

7. TRANSFER / DISCHARGE CRITERIA

- a. The consumer and his family request discontinuation of services and this request is supported by MCCMH and MISD staff.
- b. Current therapeutic goals have been met and there is no need for new ones.
- c. The consumer needs specialty mental health services and supports not available through the MISD or the therapist stationed at the school.
- d. In the case of transfer to another MCCMH program or provider, the consumer:
 - has been approved for transfer by the MCCMH Access Center, and
 - has received an appropriate “tracking number” from Access Center to assist with monitoring the transition.
- e. In the case of transfer to another provider, the consumer has been assisted in preparing for the transition. This means that the consumer knows:
 - the time, date, and location of his or her next treatment or support service;
 - knows the method of transportation that will be available to attend the appointment;
 - knows what materials he or she is to bring to the next appointment; and
 - knows how to request changes in these plans if necessary (e.g., if his/her situation becomes urgent and the appointment needs to be arranged sooner than originally scheduled).

E. CHILDREN’S HOME AND COMMUNITY BASED MEDICAID WAIVER II (Community Services to Persons with DD)

1. PURPOSE

In keeping with Michigan’s philosophy of permanency planning, and a commitment to deinstitutionalization, Children’s Home and Community Based Model Waiver II (CMW II) provides services to persons with developmental disabilities in the least restrictive and most desirable environment - the family home. The CMW II program is based on enabling legislation found in Title XIX of the Social Security Act. The legislation allows Medicaid to waive the income eligibility of the candidate’s family and to view the waiver candidate as a family of one. The purpose of the CMW II is to provide an array of community-based services to eligible children and young adults who either: currently reside with their families but are at risk of being placed into an Intermediate Care Facility for the Mentally Retarded

(ICF/MR facility); or currently reside in an ICF/MR facility but could return home with appropriate services to the family.

2. OBJECTIVES

To enhance the family's ability to provide necessary care and habilitation to their child or young adult within the home. A comprehensive individual plan of care must be flexible and written to address the specific needs of the recipient. The plan is monitored and coordinated by an interdisciplinary team. The interdisciplinary team includes, but is not limited to, the attending physician, health care manager, family, community mental health case manager who is a Qualified Mental Retardation Professional (QMRP), reimbursement staff, school personnel, dietitian, physical therapist, occupational therapist and/or psychologist. This plan must be cost effective when compared with the cost of placement in an ICF/MR facility.

3. DESCRIPTION

The CMW II program was designed to provide in-home services to children or young adults who are at risk of being placed into institutional care because of their medical needs or behavioral problems. The services provided in the home by their CMW II program are not normally funded by Medicaid. However, these same services, when provided in a nursing home or an intermediate care facility (ICF/MR) are funded by Medicaid. Recognizing that it is both cost effective and beneficial for children with mental retardation to be cared for by their families in the family home rather than being placed into an ICF/MR, nursing home, or foster care home, the federal government has authorized the State of Michigan to provide in-home services to 200 of the State's most severely affected children and their families, if the families waive the option of residential placement and accept the in-home services instead.

4. SERVICES

- a. The following "Core Services" may be provided: Psychosocial Assessment, Psychiatric Evaluation, Psychological Testing, Nursing Assessment, Supports coordination, Crisis Intervention, Person Centered Planning.
- b. Besides the "core services" listed above, the following services may be provided:
 - In-home behavioral training support up to 165 hours per month
 - In-home nursing support up to 165 hours per month
 - In-home respite hours up to 48 hours per month
 - Out-of-home respite up to 120 hours per month
 - In-home follow-up of specialized services, e.g., Occupational Therapy, Physical Therapy, Speech Therapy, Nutritional Assessment, and Didactic Services
 - Client Services Management

- Referrals to inpatient or outpatient services, including psychiatric follow-up
- Home modifications
- Purchase of special equipment, durable or nondurable, identified as necessary but not covered by private insurance

5. ELIGIBILITY CRITERIA

- a. The consumer is under 26 years of age.
- b. The consumers resides in his or her family home.
- c. The consumer has a GAF score of 50 or less.
- d. The consumer has a diagnosis of severe or profound mental retardation, or the consumer has a diagnosis of mild to moderate mental retardation with multiple handicap conditions or specific maladaptive behavioral program needs.
- e. Additionally, the person must have impairments in at least three of the following areas: (1) Understanding and use of language, (2) Self-care, (3) Mobility, (4) capacity for independent living, (5) Self-direction, (6) Learning, and (7) Self-sufficiency.

If the individual is determined to meet these criteria by the Client Services Manager (CSM), a pre-screen application is completed and forwarded to the Department of Mental Health (which administers the State program) for review. When the scoring is completed the person's name is placed on a state-wide waiting list. When a waiver becomes available, the CMW II program reviews the waiting list. The individual who has the highest composite score on the date a waiver becomes available is then given the opportunity to apply for the waiver. The CSM and other professionals in conjunction with the family, conduct assessments and develop an individualized plan of care and submit these documents to the CMW II clinical review team, where they are reviewed and assessed. Once completed the CMW II review committee will determine if the recipient is eligible for services.

6. EXCLUSION CRITERIA

The consumer is not chosen for participation through DCH review.

7. TRANSFER / DISCHARGE CRITERIA

- a. The consumer no longer experiences substantial limitations in three of the following seven areas: learning, receptive/ expressive language, personal hygiene/self care (ADLs), instrumental activities of daily living (e.g., shopping, cooking, laundry, home care), self direction/decision making, mobility, or economic self-sufficiency.

- b. The consumer has demonstrated the skills needed to maintain him/herself in the community and access resources to meet the demands and needs of daily life. They are able to obtain and maintain life sustaining essentials. This includes being able to access and utilize resources for: medication, food, transportation, medical care, entitlements, funding, and emergency care.
- c. The consumer and his family request discontinuation of child waiver enrollment and this request is supported by MCCMH and DCH staff.
- d. Current case management goals have been met and there is no need for management goals.
- e. The consumer has natural supports and community resources which are adequate for safe, independent living in the community.
- f. In the case of transfer to another MCCMH program or provider, the consumer:
 - Has been approved for transfer by the MCCMH Access Center, and
 - Has received an appropriate “tracking number” from Access Center to assist with monitoring the transition.
- g. In the case of transfer to another provider, the consumer has been assisted in preparing for the transition from one program to another. This means that the consumer:
 - Knows the time, date, and location of his or her next treatment or support service;
 - Knows the method of transportation that will be available to attend the appointment;
 - Knows what materials he or she is to bring to the next appointment; and
 - Knows how to request changes in these plans if necessary (e.g., if his/her situation becomes urgent and the appointment needs to be arranged sooner than originally scheduled).

F. CHILDRENS’ SED HOME AND COMMUNITY-BASED SERVICES WAIVER

1. PURPOSE

The Children’s Serious Emotional Disturbance Home and Community-Based Services Waiver (SEDW) program provides specialty mental health services and supports to children up to age 18 with serious emotional disturbance who are enrolled in the SEDW. Children enrolled in the Waiver can qualify

for Medicaid as a “family of one”. Children selected for enrollment are usually involved with other child-service programs, e.g., the special centers of the Macomb Intermediate School District, the 16th Circuit Court Family Division, the Department of Human Services, and/or the Macomb County Office of Substance Abuse Services. MCCMH administers the program through its contract with the State in partnership with other community agencies.

2. OBJECTIVES

- a. To remove, or reduce, the risk of hospitalization for children up to age 18 with SED who meet the criteria for admission to a state inpatient psychiatric hospital.
- b. To reduce the need for on-going services from the Circuit Court, the Department of Human Services, the Intermediate School District, as well as Macomb County Community Mental Health by providing a coordinated, multi-system response to the child and his/her family.

3. DESCRIPTION

The SEDW enables the State of Michigan to use Medicaid funds to provide necessary home and community-based services for children and adolescents with SED who meet the criteria for admission to a state inpatient psychiatric hospital and who are at risk of hospitalization without waiver services. MCCMH assessed consumers for waiver candidates, and acts to coordinate the SDEW services. There is a Wraparound Facilitator who works with the child, the child’s family, friends, and other members of the planning team to identify the child’s needs and to secure the necessary services. Planning is done utilizing the Wraparound Planning process. (See section II.C.3., “Wraparound CwSED,” herein.) SEDW consumers receive at least one SEDW service per month.

4. SERVICES

Services and supports are included in the individual plan of service, as developed through the Wraparound Planning Process. Each child has a Wraparound Facilitator, who is responsible to assist the child/family in planning and organizing the Child and Family Team, developing the plan, and coordinating services and supports. Through regular contact with the child and family, the Wraparound Facilitator monitors the supports / service delivery, and the health and safety of the child, with oversight by the community team. In addition to Medicaid state plan services, children may receive the SEDW services as identified in the individual plan of service. Services include:

- Community Living Supports

- Family Training / Support
- Respite Care
- Child Therapeutic Foster Care
- Therapeutic Overnight Camp
- Transitional Services
- Wraparound Services

5. ELIGIBILITY CRITERIA

To be eligible for the SEDW program, children must meet the medical and financial eligibility criteria that is set forth in the MDCH Medicaid Provider Manual. In general, the child must meet current MDCH contract criteria for the state psychiatric hospital, and must demonstrate serious functional limitations that impair his ability to function in the community (as measured by the CAFAS).

6. EXCLUSION CRITERIA

- a. The child is not at risk for inpatient hospitalization.
- b. The Child's CAFAS score is below the threshold specified in the Medicaid Provider Manual.
- c. The child is in out-of-home placement and is not eligible for a return in the next six months.

7. TRANSFER / DISCHARGE CRITERIA

- a. The child and/or his /her guardian request to leave the program.
- b. The child is placed in 27/7 supervised care for more than a month.
- c. The child and his family have achieved the goals established on the family-centered plan and there are no new goals to be addressed.

V. SPECIALIZED PROGRAMS FOR ADULTS

A. OBRA ASSESSMENT

1. PURPOSE

Pursuant to the Omnibus Budget Reconciliation Act (OBRA) of 1987 and general guidelines established by MDCH, MCCMH has the responsibility of providing Level II assessments to all adults who meet the eligibility criteria. The OBRA Assessment Services Component provides assessments, referrals and/or case coordination. The Level II assessment also provides treatment recommendations related to consumers' mental health care while in a Nursing Home facility. Philosophically, the program is designed to assist consumers and their families in determining the need for Nursing Home

placement and providing treatment recommendations related to the consumers mental health needs while in the Nursing Home facility.

2. OBJECTIVES

- a. To provide assessment and referral services to adults who are seriously mentally ill or developmentally disabled/mentally retarded and have a medical condition in order to access Nursing Home placement.
- b. To provide case coordination to consumers and their families in order to link the consumer with needed specialized mental health services or other mental health services to meet the consumer's needs.

3. DESCRIPTION

The OBRA Assessment Services Component provides assessment, referral and/or case coordination services to adults and their families who reside in Macomb County. Any adult who is believed to require placement in a nursing care facility and is currently located in Macomb County will be assessed unless a primary diagnosis of dementia or a comatose condition has been documented by a physician. Subsequent referral, consultation, and case coordination services are available for adults who are entering or currently reside in Nursing Home facilities. Various assessments are provided to consumers depending on their diagnosis. All consumers are provided with a mental status examination, psychosocial assessment and health care assessment. Consumers who are believed to be developmentally disabled or mentally retarded may be additionally provided with psychological testing, occupational therapy assessment and/or speech therapy assessment.

4. ELIGIBILITY

- a. Consumer is seeking admission to a Nursing Care Facility.
- b. Consumer currently resides in a Nursing Care Facility.

5. SERVICES

Diagnostic services, which may include one or more of the following:

- Psychosocial Assessment
- Psychological Assessment/Testing
- Mini-Mental Status Examination (Folstein)
- Health Care Assessment
- Speech and Language Assessment
- Occupational Therapy Assessment

B. OBRA TREATMENT AND NURSING HOME MENTAL HEALTH MONITORING

1. PURPOSE

Pursuant to the Omnibus Budget Reconciliation Act of 1987 and general guidelines established by the MDCH, MCCMH has the responsibility of providing Specialized Mental Health Services and other mental health services to all residents who meet the eligibility criteria. The OBRA Treatment Services Component provides a continuum of mental health treatment services to residents who have a serious mental illness, developmental disability/mental retardation and reside in a Macomb County nursing home facility. Philosophically, the program is designed to assist residents in stabilizing symptoms, maintain remission of symptoms, assist in arranging alternative placements and increase the potential quality of life for the resident and family.

2. OBJECTIVES

- a. To provide mental health treatment services to residents that assist the resident to successfully deal with problems associated with a serious mental illness, developmental disability/mental retardation, or adjustment to physical disability and nursing home placement.
- b. To provide service coordination, case management and/or nursing home mental health monitoring services to residents in order to advocate, link and monitor for necessary resources and, if appropriate, arrange for alternative placement to meet the resident's needs.
- c. To provide support services to families and significant others who are coping with the demands of a family member or significant other who is diagnosed with a serious mental illness, developmental disability/mental retardation and residing in a Nursing Home facility.
- d. To provide training to nursing home staff and the community in order to assist in understanding and coping with the various problems, issues and concerns related to this population.

3. DESCRIPTION

The OBRA Treatment Services Component receives referrals from the OBRA Assessment Service component of First ResourceS and Treatment (FIRST) - North. Services are provided to adults residing in a nursing home facility in Macomb County who have a diagnosis reflective of a mental illness, or developmental disability/mental retardation as detailed in DSM-IV. Currently, the OBRA Treatment Services Component has three (3) distinct treatment elements:

- a. Specialized Mental Health Services - a range of services provided to residents who at the time of the Level II assessment are deemed to

have specialized needs;

- b. Other mental health services - a range of services including individual and/or group therapy, nursing home mental health monitoring, and client services management activities;
- c. Inservice training for nursing home staff - the OBRA Treatment Services Component provides inservice training to nursing home staff in order to assist them in dealing with and understanding the various problems, issues and concerns of their residents. Assessments completed by the OBRA Treatment Services component are scheduled based upon the resident's presenting problems and time limited goals are established related to these problems. All residents receiving services are provided with a Plan of Service and progress is evaluated on a quarterly basis. A range of services may be provided to residents for the purpose of reducing maladaptive behaviors; maximizing skills in behavioral self control; restoring normalized psychological functioning, reality orientation and emotional adjustment; and assisting the residents in securing alternative living situations thus enabling the residents, family and significant others to function more effectively in interpersonal and social relationships.

4. SERVICES

- a. Individual and/or Group Therapy
- b. Crisis Intervention
- c. Client Services Management Activities

5. ELIGIBILITY CRITERIA

- a. Consumer resides in a nursing care facility.
- b. Consumer has been determined through OBRA Level II Assessment to require Specialized or Other Mental Health Services.
- c. The consumer does not meet medical necessity criteria for mental health inpatient hospitalization.