



Community Health &
Research Center

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Signature: 	Date: 6-9-2020

I. POLICY

The policy of the ACCESS Community Health and Research Center (ACCESS CHRC) provides an environment that facilitates recovery for people with mental illness, emotional disturbance, developmental disabilities and substance use disorder. ACCESS expects that recovery principles and practices are integrated in system policies, procedures, language, and documentation at all levels toward a recovery-enhancing environment. Individuals shall receive services suited to his/her condition in the least restrictive setting.

II. PURPOSE

To provide direction for ACCESS, its contractors, and the subcontractors to ensure that the individuals served receive the necessary assessments which lead to appropriate person-centered planning and referrals to other services or community resources as expected in a coordination of care approach.

III. APPLICATIONS

This policy applies to all ACCESS employees, interns and volunteers who provide support and treatment on behalf of the ACCESS CHRC.

IV. DEFINITIONS

Co-occurring Disorder: People who have substance use disorders as well as mental health disorders are diagnosed as having co-occurring disorders, or dual disorders. This is also sometimes called a dual diagnosis.

Conjoint/Collateral Therapy: a type of therapy in which a therapist sees the two spouses, or parent and child, or other partners together in joint sessions.

Coordination of Care: Collaboration between physicians, other clinical professionals and their designees within the MCPN's array of contractors and sub-contractors, MHP's, and substance abuse providers, in the provision of services to persons mutually served: This coordination of care includes sharing of relevant information such as diagnosis, course of treatment, medication and side effects and recommendations regarding treatment/services/supports for a specific person who

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is receiving services.

Home Based Services: Mental health home-based services programs are designed to provide intensive services to children and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to support families in meeting their child's developmental needs, to support and preserve families, to reunite families who have been separated, and to provide effective treatment and community supports to address risks that may increase the likelihood of a child being placed outside the home.

Manager of Comprehensive Provider Network (MCPN): A business contracting entity established to develop and manage a comprehensive network of providers that can meet the needs of adults with or at risk of developing severe mental illness; children and adolescents with serious emotional disturbances; persons with developmental disabilities; and persons with severe mental illness and substance abuse disorders.

Peer Services: A Medicaid Managed Care 1915 (b) (3) waiver and Healthy Michigan service which promotes community inclusion and participation, independence and productivity. They include Peer Support Specialists, Peer Mentors, Recovery Coaches, Parent Support Partners and Youth Peer Support Specialists.

Person Centered Planning (PCP): A process for planning and supporting the individual receiving services that builds on the individual's capacity to engage in activities that promote community life and that honor the individual's preferences, choices and abilities. The process involves family/significant other(s), friend(s) and professional(s) as the individual desires or requires.

Recovery: A life journey that allows individuals to achieve their full potential with services and supports in the community of their choice (modified and adopted by D- WCCMHA, 2008).

Recovery Enhancing Environment (MI-REE) Michigan version: A modified version of a paper and pencil self-report instrument that gathers data on mental health recovery from people who receive mental health services.

Serious Emotional Disturbance: A diagnosable mental, behavioral, or emotional disorder affecting a minor that meets the diagnostic criteria specified in the most current Diagnostic and Statistical Manual of Mental Disorders (DSM).

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Serious Mental Illness: Diagnosable mental, behavioral or emotional disorder affecting an adult that meets the diagnostic criteria specified in the most current DSM.

Substance Abuse and Mental Health Services Administration (SAMHSA): A branch of the U.S. Department of Health and Human Services. It is charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

Substance Use Disorders: Includes Substance Dependence and Substance Abuse according to selected specific diagnostic criteria specified in the most current DSM.

Support Plan: A written plan that specifies the personal support service, or any other supports that are to be developed with and provided for a recipient.

Treatment plan: A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services that are to be developed with and provided for the recipient.

Individual Plan of Service/Person-Centered Plan/Family-Centered Plan (IPOS/PCP): A written comprehensive plan of treatment/services/supports developed through a person-centered/family-centered planning process, in partnership between the consumer and one or more qualified professional (e.g., Mental Health Professional (MHP), Child Mental Health Professional (CMHP) or Mental Retardation Professional (QMRP), to address identified desires and needs and to establish meaningful and measurable goals that are prioritized by the consumer. The IPOS is the fundamental document in the individual's record and must be authenticated by the dated legible signatures of the recipient/authorized representative and the person chosen by the recipient, and named in the plan to be responsible for its implementation. The IPOS consists of a treatment plan and/or a support plan, and may be further characterized as follows:

Manager of Comprehensive Provider Network (MCPN): A business Entity contracted by DWMHA to develop and manage a comprehensive network of providers which can meet the individual's needs with or at risk of developing serious mental illness, serious emotional disturbance, developmental disabilities and/or substance abuse.

Respite: Services that are provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the unpaid caregiver and is provided during those portions of the day when the caregivers are not being paid to provide care. The methods and

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amounts of respite are decided during the person/family centered planning process

Targeted Case Management: Targeted case management is a covered service that assists beneficiaries to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process.

Treatment by Spiritual Means: Encompasses a spiritual discipline or school of thought upon which a recipient wishes to rely to aid physical or mental recovery and includes easy access, at the recipient's expense, to printed, recorded or visual material essential or related to treatment by spiritual means and to a symbolic object or similar significance.

V. PROCEDURES

ACCESS ensures that those services shall be determined in partnership with the individual/guardian and family through a person-centered planning process. This shift means new roles and responsibilities for professionals at every level of the organization. Different modalities of treatment will be summoned to provide the most individualized and holistic approach to mental health care. These criteria are delineated in the Michigan Mental Health Code, and the Michigan Department of Health and Human Services (MDHHS) Administrative Rules, the Victims of Crime Act (VOCA) Crime Victim Assistance Grant and the Office of Refugee Resettlement Torture Survival Program (ORR - TSP). The services are

1. Based upon available funding and client's funding source
2. Discuss with client
3. Provide options
4. Complete LOCUS, if applicable
5. Screen to determine stage of change, frequency of use, and optional treatment methods.

Tools used are:

- a. Addiction Severity Index (ASI)
- b. Use Disorder Identification (Audit)
- c. Drug Abuse Screening Test
- d. and/or AIMS

If a change in LOCUS is required, we work with client and provide a variety of services as determined by medical necessity.

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A. Aftercare

Each patient is encouraged to agree to aftercare services after completing the formal treatment program. A patient is eligible for aftercare services after satisfactorily completing any component of treatment via the transition process in order for an individual to move to aftercare treatment modality, a patient meets policy criteria as stated above and agrees to aftercare services.

- a. Patient may sign a treatment plan agreeing to participate in aftercare. The therapist assists the patient in formulating aftercare goals which are specific.
- b. The individualized aftercare plan may include but is not limited to any of the following:
 - i. Alcoholics Anonymous, Narcotics Anonymous, etc. Specific groups and number of groups should be specified.
 - ii. With length of time committed to using and arrangements for refill
 - iii. Self Help groups including names of groups, location and number of groups to attend
 - iv. Other organizations, identified as to name and attendance
 - v. Vocational/Educational with name and plan for attendance
 - vi. Self Help: exercise program schedule, books to read, etc
- c. Patient may renew or terminate aftercare at any time
- d. All aftercare will assure patient confidentiality

B. Behavior Plans

If an individual requires behavior management plan, he/she will be referred to an agency providing this service and that can generate a plan through the interdisciplinary team approach and reviewed by the Behavior Management Committee. Behavior management plans will be completed and monitored by that service provider.

C. Conjoint/Collateral Therapy

Therapist will provide conjoint therapy services for all patients assessed to be appropriate for this therapeutic service.

- a. At the time of assessment or at any point in treatment the therapist of patient may request conjoint therapy services.
- b. Therapist must include conjoint therapy (frequency, goals, etc.) in the patient's treatment

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- plan.
- c. Therapist facilitates appropriate conjoint counseling session focusing on the patient's treatment plan.
 - d. Therapist must document summation of session on a progress note in the patients' medical record

D. Group Therapy

A therapist assess patient for appropriateness for group therapy sessions. Therapist must include group therapy participation in the treatment plan.

- a. Therapists provide orientation to each patient assigned to group therapy.
- b. Supply a group sign-in sheet and verify that each patient is signed-in and understands the rules for group therapy.
- c. Facilitate patient interaction and group process.
- d. Document summation in the patient's medical record.
- e. Charge each therapy session on a daily basis per established procedure.
- f. Participation of patients in group therapy is limited to a minimum of 4 and a maximum of 12 patients per group.

E. Integrated Treatment for Co-occurring Disorders

ACCESS will use the integrated treatment model which an evidence-based practice and addresses the problem of access by ensuring that one visit, in one setting, is sufficient to receive treatment for both disorders. It addresses the problem of combining messages and philosophies by giving this responsibility clearly to the treatment provider instead of the client. There are several key features of integrated treatment services:

- a. **Shared Decision Making** - Shared decision making is a systematic approach to client-centered care that involves the client explicitly in the treatment process. In this approach, clients with co-occurring disorders decide what goals they want to pursue, how they want to proceed with treatment, and what their path to dual recovery will be.
- b. **Integration of Services** - When both mental health and substance use services are provided by the same person or team, the client has one treatment plan, one set of

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goals, and one relapse plan. The need for communication across agencies disappears.

- c. **Comprehensiveness** - People with co-occurring disorders typically have multiple needs. Having two illnesses can be demoralizing and can reduce a person's basic psychosocial supports. Co-occurring disorders programs, therefore, must have access to an array of services. These include, among others:
 - i. Housing
 - ii. Case management
 - iii. Supported employment
 - iv. Family psychoeducation
 - v. Social skills training
 - vi. Illness management
 - vii. Pharmacological treatment
- d. **Assertive Community Outreach** - Many people with co-occurring disorders do not come into mental health centers to seek treatment on their own. They might be on the streets, in homeless shelters, in police custody, or in jail or prison. Assertive community outreach that uses specific engagement strategies is necessary to connect them to the help they need.
- e. **Reduction of Negative Consequences** - Before people are ready to completely stop using substances, they are often willing to take some smaller steps to reduce some of the harmful consequences of their use.
 - i. When people make progress on some of these [harm reduction] goals, they become more motivated to control their substance and mental health disorders. Some professionals argue that this approach enables an addicted person to continue to use and add that, because of this enabling, addicted persons will never experience the pain of their use and "hit bottom" so they can truly recover. For people with co-occurring disorders, however, not attending to the negative consequences of addiction often leads to death. Taking positive steps often increases motivation for recovery.
- f. **Long-term Perspective** - People with co-occurring disorders recover at varying rates. Research shows that some begin to manage their illnesses in a matter of months. Unfortunately, many people enter recovery gradually, over many years. This long-

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term perspective means that we must be accepting of different paths. We must never give up. We must accept that recovery can be a life-long journey.

- g. **Motivation-based Treatment** - To effectively address a client's co-occurring disorders, treatment must target the client's stage of motivation for recovery. The idea of stages of treatment means that there are different interventions for different stages. The stages of motivation-based treatment are engagement, persuasion, active treatment, and relapse prevention.
- h. **Multiple Psychotherapeutic Interventions** - People with co-occurring disorders typically have multiple needs. Like everyone, they also have their own unique preferences and values. Needs, preferences, and values all influence their goals. Interventions, therefore, must be highly individualized and tailored to each client. Most clients engage in multiple interventions at the same time. For example, two young clients with schizophrenia and cocaine abuse could easily have different interventions. Person A might be bothered more by the interaction of schizophrenia and cocaine abuse and require residential dual diagnosis treatment plus attendance in Narcotics Anonymous. Person B might be bothered more by family problems and past trauma and need trauma intervention and family psychoeducation. Both might need supported employment.

F. Individual Therapy

Therapist will provide individual therapy services for all patients assessed to be appropriate for this therapeutic service.

- a. At the time of assessment or at any point in treatment the therapist or patient may request plan.
- b. Therapist must include individual therapy (frequency, goals, etc) in patient's treatment plan.
- c. Therapist facilitates appropriate individual counseling sessions focusing on the patient's treatment plan.
- d. Therapist must document summation of session on a progress note in the patient's medical record

G. Services Suited to Condition

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- a. Mental health services shall be offered in the least restrictive setting that is appropriate and available.
- b. ACCESS shall ensure that a person-centered planning process is used to develop a written individual plan of services in partnership with the recipient.
- c. A preliminary plan shall be developed within seven days of the commencement of service.
- d. Any treatment plan shall establish meaningful and measurable goals with the recipient.
- e. The individual plan of service shall contain pertinent information from assessments necessary to address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation and recreation.
- f. The individual plan of service shall identify the needs and goals of the recipient and the medical necessity, amount, duration, and scope of the services and supports to be provided.
- g. If a recipient exhibits challenging behaviors, there shall be a comprehensive assessment/analysis of the recipient's challenging behaviors conducted.
- h. Restrictions, limitations, or any intrusive behavior treatment techniques shall be reviewed by a formally constituted committee of mental health professionals with specific knowledge, training and expertise in applied behavioral analysis.
- i. Any restrictions or limitations of the recipient's rights shall be justified, time- limited, and clearly documented in the individual plan of service.
- j. Additionally, a description of attempts to avoid the limitations or restrictions, as well as what actions will be taken as part of the treatment plan to ameliorate or eliminate the need for the restrictions in the future shall be documented in the recipient's record.
- k. A recipient shall be given a choice of psychiatrist or other mental health professional within the limits of available staff.

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- l. If a recipient is not satisfied with his/her individual plan of services, the recipient, the person authorized by the recipient to make decisions regarding the individual plan of service, the guardian of the recipient, or the parent with legal custody of a minor recipient may make a request for review to the designated individual in charge of implementing the plan. The review shall be completed within 30 days and shall be carried out in a manner approved by ACCESS.
- m. An individual chosen or required by the recipient may be excluded from participation in the planning process only if inclusion of that individual would constitute a substantial risk of physical or emotional harm to the recipient or substantial disruption of the planning process. Justification for an individual's exclusion shall be documented in the case record.
- n. A recipient shall be informed orally and in writing of his/her clinical status and progress at reasonable intervals established in the individual plan of service in a manner appropriate to his/her clinical condition.
- o. Each ACCESS staff member, contractor and subcontractor shall establish and implement procedures that further particularize and comply with the minimum standards established by this policy.

H. Recovery

- a. **Self-Direction:** Persons in recovery determine their own path of recovery with their autonomy, independence, and control of resources.
- b. **Individualized and Person-Centered:** There are multiple pathways to recovery based on an individual's unique strengths as well as his or her needs, preferences, experiences, and cultural background.
- c. **Empowerment:** Persons in recovery have the authority to participate in all decisions that will affect their lives, and they are educated and supported in this process.
- d. **Holistic:** Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Recovery embraces all aspects of life, including housing, social networks, employment, education, mental health and health care treatment and family supports.

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- e. **Non-Linear:** A process of continual growth, occasional setbacks, and learning from experience. However, recovery is not a step-by-step process.
- f. **Strength-Based:** Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. The process of recovery moves forward through interaction with others in supportive, trust-based relationships.
- g. **Peer Support:** Mutual support plays an invaluable role in recovery. Persons in recovery encourage and engage others in recovery and provide each other with a sense of belonging.
- h. **Respect:** Eliminating discrimination and stigma are crucial in achieving recovery. Self-acceptance and regaining belief in one's self is particularly vital.

I. Section 32p Block Grant

- a. The Section 32p Block Grant combines funds formerly appropriated for Great Start Collaborative in Section 32b and for Great Parents, Great Start in Section 32j. There are changes to the funding distribution for FY 2014 and to allowable early childhood services. The funding distribution is based on an "equitable" formula, as approved by the State Board of Education. For FY 2014, some intermediate school districts will be supported in their collaborative work by funds from the Child Care and Development Fund (CCDF) in addition to the state aid funds. More flexibility in services is allowed to meet the goals identified in each Great Start Collaborative's strategic plan.
- b. **Model: Parent as Teachers**
 - i. **Curriculum:** Born to Learn 0-3 and 3 to kindergarten entry
 - ii. **Number of Children:** 120
 - iii. **Length of visit:** 60 minutes
 - iv. **Number of visits:** 12 visits per family, 2x per month
 - v. **Criteria:** Families will be selected based on the previous risk factor checklist. The ASQ will also be administered to obtain pre-post scores.
 - vi. **Staff Certification** is required and will need to be renewed yearly

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J. Targeted Care Management

- a. Targeted case management is provided in a responsive, coordinated, effective and efficient manner focusing on process and outcomes. Targeted case management services are available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.
- b. Beneficiaries are provided choice of available, qualified case management staff upon initial assignment and on an ongoing basis.
- c. The determination of the need for case management must occur at the completion of the intake process and through the person-centered planning process for beneficiaries receiving services and supports. Justification as to whether case management is needed or not must be documented in the beneficiary's record.
- d. Case management is provided in any setting that provides the best access to the person served and it's preferred by the person served. Such locations may include
 - e. residences, shelters, community resource sites, hospitals, schools, medical and other service sites.
- f. The intensity of service is determining by the person's needs and it's identified during the person-centered planning process.
- g. The Case managers' duties are:
 - i. Assuring that the person-centered planning process takes place and that it results in the individual plan of service. Activities are carried out in collaboration with the persons served.
 - ii. Assuring that the plan of service identifies what services and supports will be provided, who will provide them, and how the case manager will monitor (i.e., interval of face-to-face contacts) the services and supports identified under each goal and objective.
 - iii. Overseeing implementation of the individual plan of service, including supporting the beneficiary's dreams, goals, and desires for optimizing

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- independence; promoting recovery; and assisting in the development and maintenance of natural supports.
- iv. Assuring the participation of the beneficiary on an ongoing basis in discussions of his plans, goals, and status.
 - v. Identifying and addressing gaps in service provision. With the permission and signed consent of the person served, staff provides advocacy with the other service providers, as well as other identified community resources.
 - vi. Coordinating the beneficiary's services and supports with all providers, making referrals, and advocating for the beneficiary. Optimizing resources and opportunities through community linkages and enhancing support networks.
 - vii. Assisting the beneficiary to access programs that provide financial, medical, and other assistance such as Home Help, transportation services, exploring employment and other meaningful activities.
 - viii. Linking to skill development services needed to enable the person to perform daily activities including budgeting, meal preparation, personal care, housekeeping and home maintenance.
 - ix. Assuring coordination of care with the beneficiary's primary and other health care providers to assure continuity of care.
 - x. Coordinating and assisting the beneficiary in crisis intervention and discharge planning, including community supports after hospitalization.
 - xi. Facilitating the transition (e.g., from inpatient to community services, school to work, dependent to independent living) process, including arrangements for follow-up services.
 - xii. Assisting beneficiaries with crisis planning and identifying the process for after- hours contact.

K. Peer Services

Peer are MDHHS trained and certifies and promote community inclusion and participation, independence and productivity. Services provided will address an individual's medical needs, goals and objectives as documented in the person-centered plan. Encounters will be documented and will describe services and supports provided.

L. Treatment by Spiritual Means

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An individual will be permitted to have access to treatment by spiritual means upon request, or upon the request of a guardian, if any or parent of the minor recipient. Opportunity for contact with entities providing treatment by spiritual means will be permitted in a reasonable time. This treatment includes refusal of medication, but it does not extend to circumstances where the individual is a danger to him/herself or others and treatment is essential to prevent physical injury, or if a guardian or provider has been empowered by a court to consent or to provide treatment

- a. The right to treatment does not include the right to the use of mechanical devices or organic compounds that are physically harmful; to engage in activity prohibited by law or harmful to recipient or others; or inconsistent with court ordered custody or voluntary placement by a person other than the recipient
- b. When there is refusal of medication or treatment ACCESS may file a petition in Probate Court to order the medication or treatment.
- c. A request for this type of modality can only be denied for reasons specified in the above items
- d. When ACCESS CHRC is not electing to provide, reimburse for, or provide coverage of a counseling or referral service based on objections to the service on moral or religious grounds must furnish information about the services it does not cover as follows:
 - i. To the State, with its application for a Medicaid contract, and whenever it adopts the policy during the term of the contract
 - ii. To potential enrollees, before and during enrollment
 - iii. To enrollees, within 90 days after adopting the policy with respect to any service, with the overriding rule to furnish the information at least 30 days before the effective date of the policy. (The Service Provider does not have to include how and where to obtain the services.)

M. QUALITY ASSURANCE/IMPROVEMENT

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ACCESS Quality Assessment and Performance Improvement Program (QAPIP) must include measures for both monitoring of and for the continuous improvement in quality of the program or process described in this policy.

N. COMPLIANCE WITH ALL APPLICABLE LAWS

ACCESS Employees, interns and volunteers are bound by all applicable local, state, and federal laws, rules, regulations, and policies, all federal waiver requirements, state, and county contractual requirements, policies, and administrative directives in effect and as amended.

O. LEGAL AUTHORITY AND REFERENCES

- A. Michigan Mental Health Code, P.A. 258 of 1974, as amended; MCL 330.1710; MCL 330.1752
- B. Agency Policies (All Agency Policies refer to the most recent at the time of writing)
- C. ACCESS Policy and Procedures
 - o Screening and Access to Services and exhibits
 - o Consent to Treatment and Services
 - o Person-Centered Planning and Individual Plan of Service
 - o Treatment with Dignity and Respect
 - o Local and Alternate Dispute Resolutions

IV. EXHIBITS

DWMHA Member Handbook and RR policies